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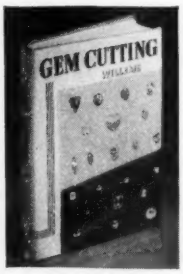

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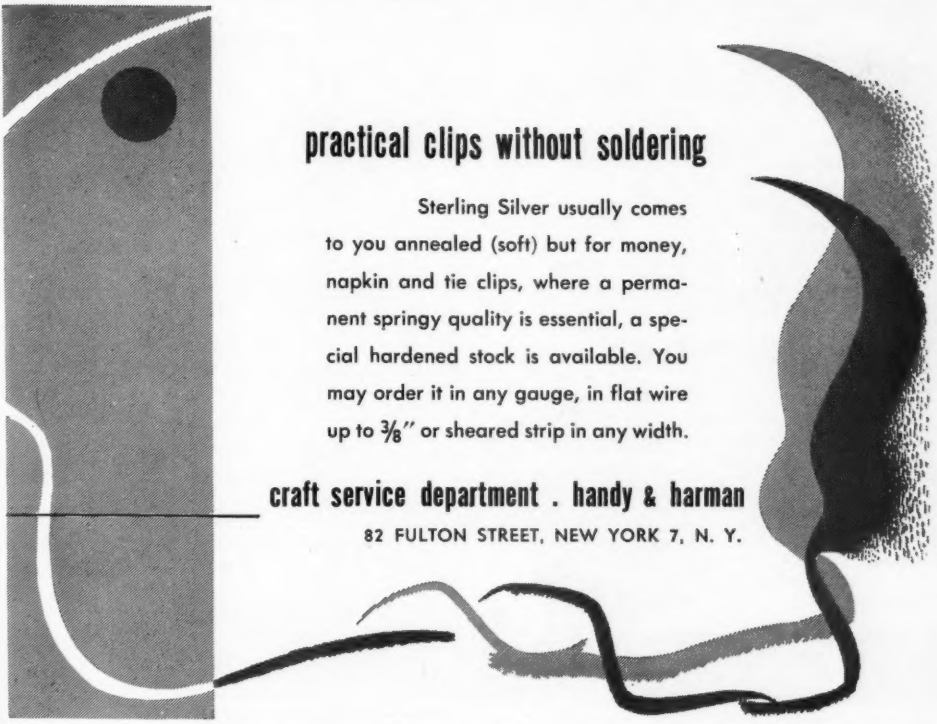

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The Balanced Posture

By ELEANOR METHENEY, Ph.D., *Professor of Physical Education*
The University of Southern California

To most people the whole subject of posture is boring. From childhood they have been told to "Stand up Straight!" "Keep your shoulders back!" "Stop lying in your chair, sit up like a lady!" Or, if they have experienced military training, "Attention!" The results of these admonitions have been negligible. Children learn to assume what they believe to be a "good" posture when commanded to do so, but the posture lasts no longer than the command.

Posture is a habit. It may be a good habit which contributes to the appearance and efficiency of the body; it may be a bad habit which spoils the appearance and makes the whole body inefficient. For good or ill, it *is* a habit which is acquired through long hours of conscious or unconscious practice. To say that posture is a habit is not the same thing as saying that it is automatic, uncontrolled, or uncontrollable. The position of the body and its parts, which is determined by muscle tonus and muscle action, is always under the control of the nervous system. This control is not always consciously maintained, but it exists nevertheless. The only unconscious and fully automatic posture is the total collapse which occurs in complete unconsciousness.

As the body assumes a given posture repeatedly, a habit of response is established in the neuro-muscular system. This response becomes habitual, so that when the individual "takes his mind off" of his posture, the neuro-muscular system makes the familiar response because it is familiar and so "feels best" to the individual. This habitual posture may be like a pair of beloved old house shoes. They may be sloppy, out of shape, down at the heels, and ill-fitting, but they are "comfortable" because the feel of them is so familiar to the foot. But if these "comfortable" old shoes are worn for eighteen holes of golf or an afternoon of shopping, the feet, legs and back soon make aching protest about the lop-sided non-supporting base which the faulty shoes provide. The habitual response of posture occurs whether the habit is bad or good, and many persons feel most "comfortable" in a posture which places a strain on every joint because they have spent so much time in the strained position that any other response of the neuro-muscular system is unfamiliar, and, therefore, uncomfortable.

To place the body in a balanced, efficient, and graceful posture for five minutes a day, allowing it to resume an unbalanced, inefficient, and awkward position during all of the rest of the waking hours, is a very ineffective procedure. The habit of years is not overcome

in five minutes. The neuro-muscular system must be given extensive and intensive re-education over an extended period of time to establish a new habit of efficient response. This re-education requires time, understanding and persistence arising from a sincere desire to improve both the appearance and the efficiency of the body.

Ten or fifteen minutes a day spent on "posture exercises" will produce very little in the way of improvement of posture. The exercises usually prescribed are intended to stretch the muscles of the chest wall and shorten the muscles which hold the scapulae back in place; strengthen the muscles of the back of the neck and shoulders; and strengthen the muscles which keep the back erect. The theory is that if these muscles are kept shortened and under tension for a sufficient period of time, they will soon automatically hold the head up and the shoulders back against the weakened pull of the chest muscles. This theory is correct in the belief that muscles may be strengthened and shortened by exercise; it is incorrect in the belief that this shortening and strengthening will *automatically* correct the carriage of the head, shoulders, and trunk. The fallacy lies in thinking that the body responds only to intentional exercise. The truth is that the body is always exercising and the effects of unintentional exercise are fully as great as, or greater than, those obtained from fifteen minutes a day of planned activity.

Take just one example. If the head is habitually carried in a forward position, the weight of the head constantly pulls on the muscles of the back of the neck, fatiguing and straining them. This strain is greatest at the point where the muscles cross the large vertebra at the base of the neck (seventh cervical vertebra). The body resents this strain and takes measures to reduce it by building up a fat pad to cushion and protect the muscles at this vulnerable point. In a few years this fat pad becomes prominent and the familiar "dowager's hump" appears. To attempt to counteract this constant pulling and stretching exercise with five minutes of forcing the muscles of the neck and shoulders to contract, is futile. The effect of sixteen hours a day of stretching is far greater than the effect of five minutes of shortening and strengthening. The plan should be reversed. "Posture exercise" should be carried on for sixteen hours a day by holding the head in the balanced, unstretched position. Then five, ten, fifteen, or fifty minutes of allowing it to bob forward would have very little effect on the total result.

This concern about posture must extend beyond the limits of the standing position. The body is always in motion, and very seldom is there any occasion for it to assume the erect standing position without moving. Static posture has little significance except as a starting point for movement. The important problem of posture, then, is not how to balance the body efficiently in the erect standing position, but how to maintain this efficiency and grace as the body moves through the work and play of a twenty-four hour day. This requires an understanding of the mechanics of movement, and an ability to apply the principles of motion and efficiency to the expenditure and conservation of energy in the moving body. Since movement in a familiar situation also becomes habitual, the achievement of efficient *movement* also requires time and practice.

Strong muscles alone will not assure efficient motion as the body moves through all of the daily activities which are its "posture exercises." In coordinated, graceful and efficient movement the opposing muscles must be able to relax and lengthen readily and easily. If the efficient body is to move freely and easily in any anatomically possible direction, all muscles must be able to relax and lengthen, just all muscles must be able to contract strongly and quickly.

The ability to feel this contraction and relaxation, to know what a muscle is doing, is called kinesthetic perception. This kinesthetic perception is also important to balanced and efficient movement, for unless the individual senses or feels the rightness or wrongness of a movement, he has no basis for correcting it or for trying to establish it as an habitual pattern. Kinesthetic perception is developed by consciously placing the body and its parts in a given position and "getting the feel" of it. This feeling of balance or imbalance, grace or awkwardness, serves as a constant guide to the body as it moves. As this feeling is developed, it, too, becomes habitual and semi-conscious and serves as a potent force in making the

daily activities serve as effective posture exercises for increasing the efficiency of the individual.

These ideas on modern posture exercise should be summarized so that they may be easily remembered, for they are important. (1) Every muscle should be strong enough and have sufficient tone to perform its functions; (2) Every muscle should be relaxed enough to perform its functions easily; (3) The joints to which the muscles are attached should be flexible enough to make a full range of movement possible; (4) Kinesthetic perception should be developed to such a degree that the body is uncomfortable unless it performs each motion with a minimum of effort to produce maximum results; and (5) Since posture exercise goes on through every minute of life, it should be controlled to produce the best results in strength, relaxation, flexibility, and efficiency.

These results can be achieved by any normal person who has: (1) An understanding of the process of movement and the principles upon which efficient movement is based; (2) The ability to control the movements of his own muscles; and (3) the desire to acquire a balanced effective posture—if that desire is strong enough to cause him to apply the principles learned to every activity of daily living over a sufficient period of time to make their practice habitual.

The body is a mass of material. Like every other mass of material it feels the pull of the force of gravity, which pulls it down toward the earth and gives it the quality called weight. It is not necessary to understand the "why" of gravity to understand its action; but an understanding of its pull on human body—or any material object — is necessary for an understanding of some of the most pertinent problems of posture.

Gravity may be thought of as a strong pulling force which draws all material objects vertically downward toward the center of the earth, holding them in contact with the earth's surface or with some other solid which in turn is in contact with the earth's surface. This force acts on all parts of every object, but it operates in such a way that for practical purposes it may be considered as concentrating its pull on the weight center of the object. This weight center is called the *center of gravity.* The line which goes vertically downward from this center to the earth's surface is called the *line of gravity.*

Every object or mass of material has a center of gravity. This point is located in such a way that if a stiff sheet of paper is passed through that point, half of the weight of the object will be on either side of the sheet of paper. This is true regardless of the direction or starting place of the bisecting paper.

When the body is in the erect standing position with the arms hanging at the sides, the center of gravity lies about two inches above the hip joint, halfway through the body from front to back and halfway across the body from side to side. The location differs slightly in every individual, depending upon his body build and weight distribution; it also shifts as the body changes position throwing more weight forward, backward, or sideward; but this general description of the position of the center of gravity will be sufficient basis for discussing its relation to postural problems.

The question immediately arises: If this force is so strong and is pulling the body toward the earth, why does not the whole body fall down into a heap on the ground? This is exactly what does happen unless some solid object is placed between the center of gravity and the ground. In the erect position the solid legs are interposed between the center of gravity and the earth. The downward pull of gravity encounters the resistance of two solid pillars, which are themselves set firmly on the earth. The downward pull of gravity then serves to keep the body on the legs and the feet on the ground. In other words, all parts of the body are pulled firmly downward toward the supporting base, which is supplied by the feet which rest on the ground. That part of the body which is in contact with the earth and through which the pull of gravity passes as it draws the body downward is called the *base of support.* If the center of gravity is directly above the base of support and solid structures lie between the center and the base, the body is stable or balanced, and the pull of gravity is counteracted by the resistance of the supporting structures.

What happens if the center of gravity does not lie directly above the supporting base? The pull of gravity meets with no resistance

and the body falls until some part of it comes in contact with the ground in such a position that the part is between the ground and the center of gravity. Illustrate this by leaning forward from the ankles (stand facing a table or some other solid object which can catch the weight of the body as it falls) with the body straight. As the body leans the center of gravity moves forward toward the toes. As it passes the toes, there is no longer any supporting base, and the body will fall forward until it is caught by placing the hands on the table. The hands on the solid table become a new point of support, and the body is supported by the feet and the hands. The line of gravity lies within the rectangle made by the feet and the hands, so forward motion is stopped because again the center of gravity lies directly above a base outlined by solid supporting structures.

Similarly, the body can lean sideward or backward from the ankles for only a short distance before the line of gravity moves outside the edge of the supporting base, balance is lost, and the body falls unless a new base is provided.

These experiments illustrate the first principle of body mechanics: *A body is stable or balanced when the center of gravity is over a supporting base.* Or, turning the statement around, whenever the line of gravity passes outside the area enclosed by the supporting base, balance is lost, and the body moves downward until a new base is provided which lies directly below the center of gravity.

If the supporting base is very small, it is more difficult to maintain balance, for very slight movement may shift the center of gravity to such a position that the line of gravity passes beyond the edge of the base. Then balance is lost and the body falls until the necessary adjustments of center and base are made. From this it is evident that if the base is large, there is less chance that the body will be unbalanced.

However, the base may be large but the line of gravity may fall very near to one edge of it. This kind of balance is also precarious, for a small movement in the right direction may move the center of gravity past the edge of the base, and balance will again be lost. Regardless of the size of the base, it is easier to maintain balance if the line of gravity falls near the center of the supporting base, rather than close to the edge.

Stand with the feet parallel, three to six inches apart, with the weight of the body evenly distributed between them. The center of gravity lies directly above the space between the feet, and the line of gravity passes down between the legs. Note how the weight is borne equally by the legs, and the pressure is felt equally on the soles of both feet.

Keeping the body straight, slowly lean forward from the ankles. Note the "falling forward" feeling as the line of gravity moves toward the toes. Note the feeling of pressure on the balls of the feet and the toes and the diminished pressure on the heels. The weight line is passing through the front part of the foot, and the heel is playing little or no part in the work of resisting the pull of gravity.

Shift the weight of the body to the right side. Note the decrease in pressure on the left foot and the increased pressure felt on the sole of the right foot. The line of gravity is now passing directly down through the right leg and the left leg is relieved of its weight bearing responsibility.

Return to the position in which the weight is felt evenly on both feet. Without shifting the body weight in any way, try to lift the right foot off the ground. It is impossible, because the pull of gravity is passing through the leg and the foot must be kept on the ground to provide a supporting base which will permit the leg to resist this pull of gravity. To lift the right foot from the ground, it is first necessary to shift the weight of the body to the left leg to free the right leg from its supporting function.

With the weight on the left leg, lift the right foot from the ground. Note how much more difficult it is to maintain balance on one foot than it is on two. The supporting base is smaller and it is more difficult to keep the line of gravity within the confines of the smaller base. Rise to the toes of the left foot, and note how the difficulty in maintaining balance increases. The base is now so small that a constant series of fine adjustments are necessary to keep the weight of the body so arranged that the line of gravity falls exactly

within the narrow limits of the supporting base of the toes.

Lie flat on the floor. This is a very stable position in which balance is easy. The supporting base is now very large and the line of gravity has no difficulty in staying within this big area. Get up on your hands and knees. This is the posture of the four-footed animals. Note how much more stable it is than the human posture. The hands and legs form four corners of a large base of support, and the center of gravity lies well within the limits of this large supporting base.

As man rose from the four-footed position and attempted to stand on two feet, he changed from a stable position in which his center of gravity was centered over a large supporting base to a position in which he attempted to balance a long, narrow body over a very small base. As a four-footed animal he had no difficulty in keeping his main line of gravity within the area of a large base; as a human being he had to solve the problem of keeping the center of gravity of his long, wobbly body over a ten to fifteen inch square. This is a difficult mechanical problem, and it is a tribute to the ingenuity of the human being that he solve it at all. As each child learns to stand erect, he must solve the problem for himself all over again, and in doing so he must learn to make adjustments in body position which will give him the maximum amount of stability with the minimum amount of effort.

Up to this point the problem of balance has been made to appear simpler than it is by considering the body as a single mass of material. Unfortunately or fortunately the body is not a solid structure, but a jointed structure with many movable parts. As any part of the body moves, the total body acquires a new shape and a different distribution of its weight, and the center of gravity shifts with this new weight distribution in order to maintain the condition of having equal amounts of weight on all sides of it.

If the supporting base is not changed as parts of the body move forward, backward, or sideward, and the line of gravity may move outside of the area of the supporting base unless some other part of the body to move in the opposite direction from the original movement so that the weight is still evenly distributed about the original center. This adjustment is made more or less unconsciously as the body learns to maintain its balance and keep from falling.

Observe how these adjustments are made by moving parts of the body and noting the result on the whole body. In the erect standing position raise both arms forward. Note how the upper back, and possibly the hips, moved backward to balance the weight of the arms. Swing both arms to the right side, and note that the hips shift to the left to keep the body weight centered over the feet. Bend forward from the waist. Note how the legs slant to throw the hips and buttocks backward. Raise the right leg forward and note the shift in the position of the supporting left leg and the instinctive motions of the arms as they are raised to balance the body over the narrow base of the left foot. Allow the abdomen and shoulders to slump forward in the posture of fatigue. Note how the hips and buttocks move backward to compensate for the forward shift in weight.

Whenever one part of the body is moved away from the line of gravity in any direction, an opposing part is moved in the opposite direction to maintain balance. This compensated or zig-zag balance is somewhat precarious since a slight shift in any of the parts involved in it may upset the entire structure.

Because the body is a jointed structure made up of a number of separate movable parts tied together at the joints and held together by a covering of skin, the pull of gravity on each separate movable part must be considered as well as the pull of gravity on the body as a whole. Each separate part has its own center of gravity and each separate part rests on its own base. The head rests on the neck; the neck bones lie above the rest of the spinal column which must support not only the neck but the weight of the head on top of the neck; the trunk is supported by the upper part legs, but must in turn support the weight of the neck, the head, the shoulder girdle, and the arms which hang from it; the upper part of the legs rests on the knee joint at the top of the lower legs, and these lower legs must support not only the thigh, but the trunk, the shoulder girdle and arms, the neck and the head. The lower legs are supported by the ankle joints

which are supported by the bones of the feet, and ankle joints must bear the combined weight of the lower legs, upper legs, trunks, shoulder girdle and arms, neck, and head. Gravity pulls through the center of each of these parts, through the common center of each combination of parts, and through the center of the entire structure.

If the center of gravity of the head does not lie directly above the supporting base of the neck, the force of gravity pulls the head downward. This pull is resisted by the muscles and ligaments of the neck which keep the head from falling off. There ensues a continual tug-of-war between gravity, the pulling force which never rests, and the muscles and ligaments of the back of the neck, which can not let go but which do become very much fatigued and stretched from the constant strain placed upon them. The unbalanced position of the head threatens the balance of the entire body unless some compensation is made by shifting some other part of the body backward to equalize the weight thrown forward by the head.

The center of weight of the shoulder girdle with its dependent arms must be centered over the spinal column, which provides its support. The center of gravity of the trunk, shoulder girdle, neck, and head combined must lie directly above the pelvic girdle, which in turn must rest squarely upon the supporting legs, or again muscles and ligaments must work constantly to offset the pull of gravity downward, which will unbalance the entire body.

Total balance is maintained with a minimum expenditure of energy by balancing each movable body part securely on its own supporting base, so that the pull of gravity on it serves only to hold it firmly in line with the rest of the body. Total balance is maintained by a wasteful expenditure of energy when any part is allowed to move forward, backward, or sideward so far that its own partial center of gravity lies outside the limits of the base which supports the part. When any part projects beyond its supporting base, the pull of gravity tends to drag it farther downward toward the earth, and this pull must be combated by an equally strong pull in the opposite direction exerted by the muscles and ligaments which hold the part in place. In addition, another part of the body must be moved out of line with its base in the opposite direction to maintain the total balance of the body. This compensated or zigzag balance is not only energy consuming, but unstable because it is easily upset by the shift of any of the parts involved. This posture resembles the many-branching Christmas tree which is easily upset by the slightest breeze or touch unless it is held in position at the base by heavy weights. Each branch projects beyond the base, and must be balanced by a branch on the other side which projects an equal distance. A light touch or small weight applied to one of these projecting branches is sufficient to topple the whole tree.

The balanced posture is like a stack of building blocks set squarely one on top of another. Gravity pulls downward on each block, but because the center of gravity of each block lies directly above the supporting base of the block below, the stack does not fall, but is held firmly together by its own weight. The blocks may be moved slightly out of line, but the pile will continue to stand as long as the center of gravity of each block and the combined center of gravity of all blocks above it continue to lie above the base of support. As soon as they are moved far enough to cause the line of gravity to pass outside the base they will collapse unless they are held in place by some resisting force.

When the center of each part of the body lies directly over the base which supports it, gravity becomes a force which pulls the body together. When any part is projecting out of line and is totally or partially unsupported by its base, gravity becomes a force to pull the part farther out of line, and this pull must be combated by the ligaments and muscles which hold the part to the body. The secret, then, of maintaining total body balance with a minimum expenditure of energy, is to cooperate with the pull of gravity, to work *with* gravity not *against* it.

Balanced posture is achieved by carrying each body part in such a position that it balances as securely as possible on the part below which acts as its base. The direction and distance which each part can move out of line with its base is determined by the construction of the joints which attach the part to its supporting base. Movements in some directions can be made easily and occur frequently; other movements are made less easily and seldom occur;

still other movements are quite impossible and are of no concern in the study of the balanced posture. In attempting to balance the parts of the body for economical posture, it is best to concentrate on those motions which are most likely to take place. For example: The head and neck may be bent forward easily and over a fairly long distance. It is difficult to bend the head and neck very far backward. If the head is going to move out of its balanced position on the neck, it is more likely to fall forward than it is to fall backward. The problem of balancing the head and neck on the shoulders is primarily one of keeping them from falling forward and exerting a pull on the muscles of the back of the neck.

It will be well to restate the principles which have been developed and illustrated as they apply to the parts of the body. They are the same as those for the body as a whole, but because the jointed structure is more complex, the principles which apply must be stated a little more fully.

1. Any part of the body is stable and balanced when the center of gravity of that part, and the parts above it, is directly over the supporting base.

2. If the line of gravity passes near the edge of the supporting base, balance is easily disturbed. Therefore, balance is most easily maintained when the line of gravity passes near the *center* of the supporting base.

3. As the line of gravity of one part moves beyond the edge of the supporting base the balance of the whole body will be lost unless some other part is moved out of line in the opposite direction, or unless an opposing force is applied to maintain the body in the unbalanced position.

The "balancing act" which is described below is based on the application of these principles. Bearing in mind the fact that balance is easily lost when the line of gravity lies too close to the edge of the supporting base, an attempt is made to find a position in which the respective gravity lines have ample room to move in all directions without going beyond the edge of the base. In the position of maximum balance there will be a *margin for movement* in all directions at each joint.

Stand with the feet on the floor a comfortable distance apart. Move them close together and notice the feeling of insecurity which the narrow base induces. Put the feet far apart. The base is now wider, but the legs slant outward so that the weight of the body is carried toward the inner edge of the knee joint and the ankle joint. Neither position gives a good base for balance, the one because it is too small, the other because the weight bearing legs are not in line with the body and because the range of motion for the legs is limited to either side. Take the position halfway between these two extremes, with the feet a comfortable distance apart so that the legs come straight down under the body.

From this position, move the toes outward into the "toe-out" position. This increases the size of the base by increasing the angle between the feet, but the advantage from the larger base is less important than the strain on the ankle joint caused by having the weight of the body borne by the inner sides of the joints. Try the "toe-in" position. The size of the base is reduced and the knee-joints are turned in to allow the foot and leg to rotate inward. Again, neither extreme position of the feet is desirable as a base for balancing the body. The feet should be in an approximately parallel position, a few inches apart, to give the most support with the least amount of strain on the joints and muscles of the feet and legs.

With the feet in this parallel position, rock the body backward and forward from the ankle joint, noting how the pressure on the soles of the feet moves first back toward the heels and then up toward the toes. For maximum support the pressure should be distributed evenly over the heel and ball of each foot, and the body should be able to rock either backward or forward without endangering its balance. Rock the body backward and forward a few times and gradually let it come to rest over the feet in this balanced position.

Keeping the feet flat on the floor and the back erect, bend the knees forward. As they bend note the pull exerted by the muscles of the lower leg and thigh so hold the body upright in this unbalanced position with the upper and lower leg making an angular instead of a straight support for the upper body. Straighten the knees, pushing them backward as far as they will go. They will move backward only slightly, then the joint locks and no

further motion is possible. This position leaves no margin for movement backward. Slightly bend the knees, then straighten them forcibly. Do this several times and gradually find the position in which the knees are neither bent nor pushed backward. This slightly relaxed position of the knee gives maximum support and still leaves room for the knee joint to move backward if the need for such motion arises.

The hip joint permits of much motion forward, but this big forward motion is not likely to occur in the erect position since it throws the entire weight of the trunk forward and makes balance very difficult and fatiguing. But the trunk moves easily forward on this main hinge of the body, and a slight forward bend frequently occurs. Bend slightly forward from the hip joint, then move the entire trunk backward from the hip joint as far as possible. Note how the knee joint immediately locks in the backward position as the center of gravity of the trunk moves backward. Move the trunk backward and forward slightly at the hip joint, feeling the movement of the entire leg, knee, and ankle joints as the legs attempt to compensate for the forward or backward position of the trunk. Bring the trunk into the position which makes it possible for the legs to remain straight down under it with the knee and ankle joints relaxed and the pressure equally distributed between the heels and balls of the feet.

Be sure this balance is also effected from side to side. Shift the weight to the right leg, then back to the left leg. Then find the balanced position in which the weight is borne equally by both legs.

To bring the pelvis into the balanced position directly under the trunk which it is designed to support, first rotate the pelvis through its entire range of motion forward and backward. With the back of the pelvis sloping backward and outward note how the trunk is deprived of support in front. Note also how the entire body weight shifts backward, locking the knee joints and putting the weight pressure on the heels. With the back of the pelvis sloping downward and forward, note the tendency to bend the knees and to round the upper back in order to compensate for the unbalanced position of the pelvis and abdomen. Move the pelvic girdle backward and forward a few times, finally placing it in the position directly under the trunk from which it can move either forward or backward with ease. Try to get the feeling of having the trunk "sit down" in this pelvic basin, so that the abdominal viscera will receive maximum support from the bony and muscular walls of the pelvis.

Raise the chest high and force it forward. Note how the upper back is forced backward to balance the chest, increasing the inward curve of the lower part of the spine. Let the chest collapse to its lowest and most sunken position. Note how the abdomen protrudes and the head is brought forward beyond the balanced line. Move the chest between these two positions, allowing it to come to rest in a position half way between these two extremes. Get the feeling of pulling *up,* not out, at the top of the flat bone to which the ribs are attached (the sternum). Place a finger and thumb in the hollow at the top of the sternum and gently lift the chest upward. Pull it as high as possible and then allow it to relax slightly. In this position the upper part of the spinal column, to which the ribs are attached, is almost straight, and the ribs hang from it in a position which makes motion up and out, in and down, easy and economical.

Raise the shoulders toward the ears. Drop them down as far as possible. Move them forward and backward and note the resulting muscle pulls and tensions across the back. The base of support of the shoulder girdle is very complex, and the weight is borne indirectly at several points. The clavicles are joined to the sternum in front, and the sternum derives its support and indirectly from the rib cage which is attached to the spinal column in back. The scapulae have no joint with the spinal column, but are attached to the back wall of the rib cage with the flat muscle fibres which hold them in place. The head of the upper arm fits into the joint between the clavicle and the scapula on either side. Muscles attached to the upper arm bone cross the shoulder joint and attach to the clavicle, the scapula and the vertebra of the neck and upper back. This complicated support makes the shoulder girdle something like a wooden yoke used for carrying water buckets, the arms taking the place of the dangling buckets. The yoke gets its support

from the spinal column. If it is carried too far forward it tends to bend the body forward; if it is carried too far back, it tends to overbalance the body backward. It is carried most easily in the mid-position with the buckets hanging straight down with their weight line parallel with the line of the spinal column. Find this position for the shoulder girdle and arms by moving them forward, then pushing them back as far as possible. Move back and forth between these two positions, and allow the shoulders to come to rest half way between them. This position can also be found by hunching the shoulders up toward the ears, then following them to drop down easily.

Finally, find the balance point for the head, raise the chin and force the head backward. Then allow the head to drop forward until the chin almost touches the top of the sternum. In both positions strain is felt on the muscles of the neck. Move the head back and forth between these two positions, gradually decreasing the amount of movement in each direction. Find the position mid-way between the "nose-in-the-air" and the "chin-on-the-chest." Let the head come to rest in this position, getting the feeling of having it set squarely on top of the column of the neck, with the chin making approximately a right angle with the neck in front and the bulge of the back of the head extending beyond the line of the neck in back for balance. In this position the weight-bearing line from the head passes directly down the column of the neck and the weight is borne by the spinal column.

Actually this whole procedure of finding balance points is not a balancing process, for balance has been destroyed at each joint by the experimental movements of the body parts above the joint. It has been done as a means of developing kinesthetic perception, of getting the feel of putting the body in unbalanced and balanced positions. Concentration on each of these movements has developed a feeling of tension, and the resulting posture is far from comfortable.

Relax, and let the whole body slump. Then quickly put the body back in balance by mentally pulling up through the top of the head and down through the entire line of the spinal column. Get the feeling of being suspended from a hook in the top of the head, with a heavy tail hanging down from the end of the spine. The tail should pull straight down. Do not let it stick out in back or curl down under between the legs. Let it pull straight down against the upward pull of the hook on top of the head.

Slump again, and quickly and easily return to the balanced position by bringing the top of the head up until it just barely touches but does not support an imaginary bucket of water hanging directly overhead. Do not strain or stretch, but reach easily with the top of the head. Mentally check the possibilities for movement at each joint. Is the weight evenly distributed over the soles of the feet? Is forward and backward movement possible at the ankle joints? Are the knees relaxed and easy so that they can be pushed backward without strain? Is the trunk balanced on the hip joint, neither toppling forward nor bending backward? Is the pelvic girdle directly under the trunk with the trunk resting securely in its basin? Can the pelvic girdle move backward and forward easily? Is the chest raised so that it can either extend farther or sink deeper? Are the shoulders hanging easily from their support? Can they move forward, backward, up, or down with ease? Is the head set squarely on the neck with no strain on the muscles either in front or in back? In brief, is there freedom to move at every joint?

There should be no tension and no feeling of being in a "held" position when the best possible balance has been achieved. It is a position of ease, for there is freedom to move in each anatomically possible direction at every joint. This freedom to move makes the balanced posture a *position of safety,* for the body is able to "Give" in any direction to absorb the force of a blow or an unexpected movement. If there is no "give" to take up the force of the blow, the ligaments and tendons will be stretched and torn. If there is even a very small amount of freedom to move, the body can adjust to the shock or movement and it will do no harm.

Dr. Goldthwait, one of the greatest of orthopedic surgeons and teachers of body mechanics has graphically described the importance of the freedom to move:

> Any joint, no matter how much or how little motion it may have, is in danger of being injured if, for any reason, its motion is forced beyond the normal range. For purposes of description we can compare a joint to the hinge on the door of an automobile. Automobile doors all have stops to prevent the door from swinging too far open; these stops are like the ligaments. Many of us have had the experience of seeing an automobile door left open so that the stop strap, or ligament, is tight, and then pushed still farther open. The result is a broken strap, a broken hinge, or a broken door, or all three. The potential reason for this accident is that the door was at one extreme of its motion and that, the stop strap, or ligament, being tight, there was no so-called factor-of-safety motion left. The actual reason was the blow on the door; the same blow, if the door had not been at one extreme of its range of motion, and so had a factor-of-safety motion, might not have caused any damage. The significant fact here, therefore, from the point of view of safety or health, is not the blow but the position of the door when it was struck, in relation to the limits of the possible range of motion in its hinges.

The balanced posture, with its factor-of-safety motion, places the body and its parts in a position of safety with its ligaments and muscles unstretched and, therefore, ready to act to absorb the shocks or jars which occur in standing on a jolting streetcar, stepping down suddenly from a curbing, or being pushed about in a crowd.

The balanced posture, which makes full and effective use of the force of gravity by aligning all parts so that the pull is directly downward through supporting structures, reduces to a minimum the work done by the muscles in maintaining the body in an erect position. The muscles and ligaments around each joint serve only to hold the part in place, cooperating with the pull of gravity instead of constantly having to work against it. The less work muscles have to do, the less energy they expand, and the less fatigue they experience. The balanced posture is, therefore, the economical posture. That it is also the most attractive and graceful posture, is only an additional dividend.

If this balanced posture be examined for weak points to discover the places at which it is most likely to go to pieces, it will be noted at once that the hip joint is the main hinge of the body and the one most likely to be destroyed by unbalanced weight distribution or lack of control. In the erect posture the position of the hip joint and the pelvic girdle is controlled primarily by the muscles of the abdomen and the buttocks (gluteal muscles). If these muscles have poor tone or the ability to control them is inadequate they are unable to perform easily their function of controlling the position of the pelvic girdle. When this is true, balanced posture is almost impossible to achieve. If this control is lacking, the posture quickly becomes unbalanced, and the zigzag erect position is maintained by allowing the body weight to literally "hang from the ligaments."

To emphasize the truth of the statement that abdominal and gluteal control are the fundamental elements of the balanced posture, experiment with various positions of the pelvic girdle and obdominal wall. Assume the position of "fatigue slump" with abdomen protruding, pelvic girdle rotate backwards, chest sunken, and shoulders and head forward. Now without changing the position of the pelvic girdle or the abdomen, try to bring the head up to the balanced position. Try to raise the chest to its ease action position. Try to straighten the shoulders so that they hang easily from the spinal column. These "corrections" are difficult and made with much discomfort, so long as the pelvic girdle and abdominal wall are in bad position.

Assume the "sway-back" posture with the hips thrown backward. Without changing the position of the pelvic girdle, try to relax the shoulders and let them hang easily. Try to balance the head comfortably on the neck. Try to unlock the knees. Again these adjustments are difficult or impossible so long as the pelvic girdle maintains its unbalanced position.

Now reverse the experiment. Bring the pelvic girdle into the balanced position with the abdominal wall held flat (but not sucked in) by easy muscle control. While holding this balanced pelvic-abdominal position, attempt to push the head forward. Try to push the shoulders forward or backward. Try to lock the knees in the backward position. Rock the weight forward over the toes and backward over the heels. Each of these unbalanced positions is difficult and uncomfortable to maintain so long as the pelvic girdle remains in the balanced position and so long as the abdominal wall is under control.

These experiments serve to demonstrate that the keynote of the balanced posture is good abdominal-pelvic-gluteal control. This control can be achieved only if the abdominal and gluteal muscles are kept in good tone and kinesthetic perception of the action of these muscles is developed. For some individuals, this will require planned exercise for the abdominal and gluteal muscles; for others the necessary tone and control can be maintained by using the muscles correctly as they carry on their daily activities.

This recognition of the major role played by good abdominal-pelvic-gluteal control in the attainment of the balanced posture greatly simplifies the whole postural problem. If this important part of the body is maintained in the balanced position, most of the other postural problems will either solve themselves or will need only minor adjustments. Dr. Kathryn Wells, an outstanding teacher of body mechanics, has reduced the problem of the balanced posture to one simple sentence. "Keep your feet under your pelvis, and your pelvis under your trunk." This is easy to remember, and its remembrance makes checking on the balanced posture simple. If the supporting base of the entire body and the supporting base of the trunk are in line, the posture is reasonably well balanced. If the pelvic girdle falls ahead of or in back of the feet, or if the trunk tends to fall ahead of or in back of the pelvic girdle, then the body is out of line and no correction is possible until basic correction of alignment is made.

In this day of alphabetical agencies and slogans, it may be easier to reduce this sentence still farther to the six letters: FPT-MFP. Translated, this reads: Feet under pelvis, pelvis under trunk — means fine posture.

Now apply this slogan to get more practice in kinesthetic perception and in correcting a faulty posture to make it a balanced one. Assume the fatigue slump posture, and note how the pelvic girdle falls backward of the feet and the abdomen forward of the pelvic girdle. Correct this posture by bringing the feet, pelvis, and trunk in line. Assume the sway-back, locked knee position. Note again that the trunk makes an S-curve above the pelvic girdle, while the legs slant backward away from the heels to meet the protruding pelvic girdle. Correct this posture by bringing the feet, pelvis, and trunk back into line. Do the same for the back-on-the-heels posture, the forward lean, the weight-on-one-leg with the opposite hip stuck out posture. In each position the basic principle of FPT is violated. Each posture may be corrected to the position of the balance by applying FPT.

The most important factor in balancing posture must be supplied by the individual — the desire to acquire the habit of balancing the body parts in such a way as to relieve muscles from strain, the desire to acquire the kinesthetic perception of muscle action required to achieve this balance, and the persistence to practice placing the body in the balanced position frequently enough to establish the new neuro-muscular pattern and make it familiar, and, therefore, comfortable. This is the hard part, for it is difficult to blot out an old, familiar pattern in the neuro-muscular system — but unless this is accomplished, no permanent improvement in postural balance will be made.

This practice should be carried on at intervals throughout the day without interfering in any way with other activities. Walking through a doorway to enter or leave a room may serve as a cut to remember: FPT. Standing on a crowded streetcar, absorbing the jolting and swaying motion, is a good time to practice: FPT. The act of rising from a chair to the standing position may serve as a reminder: FPT. Standing before a class to make a report, confidence and assurance will increase if FPT is first observed. This incidental practice is the most important kind, for it relates the balanced posture to the necessary, important, or interesting activities of living, and the balanced posture soon becomes such an integral part of those activities that it is assumed unconsciously as the most comfortable basis for meeting all situations.

Attaining a balanced standing posture is only the beginning. The principles of efficient mechanics must also be applied to achieve and maintain the balanced posture in motion, while the body is at work and at play. Time does not permit an extended development of those principles, but they are listed below for the information of those who wish to continue further exploration into the efficiency approach to the teaching of body mechanics.

1. When all parts of the body are balanced, the force of gravity pulls the body together. When any part is unbalanced, gravity pulls that part toward the earth, and force must be exerted by the muscles to hold the part in place.
   (a) Balance is maintained by keeping the center of gravity over the base of support. (Keep the feet under the pelvis and the pelvis under the trunk.)
   (b) Balance is maintained most easily when each part is *centered* over its base, allowing freedom to move in each anatomically possible direction. (The position of safety.)
   (c) Balance is maintained more easily if all parts are kept close to the line of gravity. (The Christmas tree-base principle.)
   (d) External weights added to the body become part of the total body weight and affect the location of the center of gravity.
      (1) The effect of such weights increases with their distance from the center of gravity. Therefore, keep additional weights close to the center of gravity and as nearly as possible over the base of support.
      (2) Adjust the position of the total body-plus-weight *as a unit,* beginning the adjustment at the base of support, not at the point at which the weight is added.
   (e) If the stability of the body is threatened, balance can be more easily maintained if the base of support is increased in size. (Spread the base for stability.)
2. When the body is in motion, balance is maintained more easily if a new base of support is prepared *before* the center of gravity is moved from its original base. (Lead with the thigh, not the head.)
3. To move the body or any external object, force must be applied. This force is most effective if it is applied directly through the center of gravity in the direction in which movement is desired.
   (a) Force applied above, below, or on either side of the center of gravity causes the body or object to rotate about its center of gravity as it moves in the direction of the force. (Don't push on a corner.)
   (b) Rotary motion set up by indirectly applied forces must be combated by the application of resisting forces supplied by opposing muscles.
   (c) The center of gravity of the body is approximately at the level of the hip joints. For efficient movement, all major motions of the trunk and legs should originate or pass through this joint. (Move from hips, not the waist line.)
4. Strong muscles perform a task more efficiently than weak of small muscles. For any given task, the strongest muscles available should be used. (Lift with the legs, not with the back.)
5. The movement of any part about a joint is limited by the ligaments which hold the joint together. Sudden or uncontrolled shifts of weight throw the weight of the part against the ligaments, stretching and weakening them. Weight should never be thrown against a joint unless the opposing muscles are prepared to receive it.

Read at the Annual Meeting of the American Occupational Therapy Association, 1947.

Occupational Therapy with Eye Patients: Separative Retinas

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Since occupational therapy with eye patients is a fairly comprehensive subject, only the O.T. treatment of separative retina patients will be discussed here. However, the principles described are applicable to all eye patients who have both eyes temporarily bandaged such as corneal transplant, foreign body, cataract, glaucoma, and squint cases. A brief discussion of the symptoms and treatment of the separative retina condition will show why this type of case is of particular interest to occupational therapists.

Separation of the retina may occur at any age, but most frequently between 35 and 65, and chiefly in myopic eyes. The posterior portion of a myopic eye becomes progressively elongated, placing the retina on a stretch so that trauma such as jarring of the body, a blow on the head or eye, or a perforating injury of the eye may dislodge it. Also, if previous disease has caused adhesions between the vitreous and the retina, the vitreous, whose size remains constant, may tear a hole in the retina. The vitreous will seep in the hole and between the two primitive layers of retina, causing a separation. The retina does not detach as a whole. Another cause is cystoid degeneration of the retina.

The subjective symptoms of retinal detachment are sensations of light, flickerings and sparks when the eye is moved, then a dark cloud appears in the visual field. The loss of vision depends on the location of the separation, its extent and duration, and complicating factors such as myopic fundus changes and vitreous opacities. The detachment gradually extends if untreated until it is complete, and eventually even light perception is lost.

Part of the treatment of separative retina at the Massachusetts Eye and Ear Infirmary consists of at least three weeks complete bed rest with both eyes covered and sandbags under the pillow to keep the patient's head as nearly motionless as possible. The patient has to be fed at mealtimes and the men cannot be shaved. After the first week of bed rest an operation developed by Safar is performed, consisting of diathermy points perforating the retina and choroid, causing an adhesive choroiditis which fixes the retina in place. Then the patient remains in bed for two weeks, receiving at the end of this period opaque glasses with a hole about ¼ inch in diameter in the center of each lens so that the eyes look straight ahead all the time. The average length of hospitalization is about one month, but following discharge the patient is subject to a long convalescence at home, avoiding strain, exertion, bending over, and reading, and he must wear his pinhole glasses for two or more months.

As an over-all average, about 50% of retinal detachment cases can be cured, some requiring more than one operation, with the percentage of success diminishing with each operation. In many cases the patient's other eye may continue to have normal vision, or perhaps the same predispositions may lead to retinal separation of that eye.

This description of symptoms, treatment, and results should interest the occupational therapist for several reasons. The long period of bed rest is most trying for the patient: he is liable to become bored or depressed. He is denied most of the resources for enjoyment that hospital patients have. The immediate concern of the therapist is to keep the patient as busy and happy as possible while occupying him with treatment media which require very little exertion and no sight. The secondary purpose is to provide activities which have hobby-value and will carry over into the the period of enforced idleness after the patient is discharged, and thirdly, to give training in touch sense through graded treatment to help the patient adjust to temporary and possibly permanent blindness.

The following case history illustrates some of the procedures and treatment media used:

Age: 22 *Sex:* Male Married
Diagnosis: Separative Retina, O. S.
Admitted to hospital: 4-5-48 to O.T.: 4-9-48
Discharged from hospital: 5-1-48 from O.T.: 5-1-48
Nationality: American
Occupation: Refrigerator service man
Referred by Dr. P.

This patient's initial response to O.T. was only fair; he seemed reserved and apathetic, and it was difficult to establish rapport with him. However, he was willing to try O.T., and the first project given him was a leather link belt, in which he showed good manual dexterity and learning ability but poor touch sense, being unable to distinguish the rough from the smooth side of the leather. It was suggested that he rub the pieces of leather against some more sensitive part of his body such as his upper arm as a check on the rough and smooth sides. When he was seen the next morning he had made only one error, and when it was pointed out, was perfectly willing to correct it. His enthusiasm increased greatly following the successful completion of the belt, and his following project was a looper potholder in which he demonstrated excellent concentration and persistence, making up for what he lacked in touch sense with care and resourcefulness. At this point it was learned that he led a boy scout troop and was anxious to learn new crafts to pass on to the members. Since his next graded treatment medium was to be knotting, it was given in the form of a lanyard. He mastered this with ease, and completed it up to the running in of the ends of cord. On a piece of scrap leather he then learned how to use the precision punch and lace with the whip and buttonhole stitches; with this preparation he did a perfect job punching a small change purse and lacing it with the buttonhole stitch.

Since his bandages were due to stay on for several days longer than he had anticipated, it was felt he should have a longer project that would keep him occupied more constantly. So he started a 12-strand knotted belt, seeming to have the interest and determination — for a great amount is required — to carry it through. So he did, all the way through the half hitches, then found out that his wife, who was pregnant, had already outgrown it! He cheerfully went back and lengthened it, and had just refinished it when his bandages were removed.

Throughout this last project it was very evident to what extent this patient was using his insight to reinforce his mediocre touch sense; when a strand of cord was lying slackly on the sheet he was practically unable to detect its presence, but when in the course of his gropings he happened to grasp a strand and pull it taut he knew he had it. Therefore, whenever he removed a strand from the grooves at the base of the frame he would hold the end of it between his teeth to hold it on a stretch; this and many other devices he developed on his own initiative to check on his accuracy. The success of these methods was demonstrated by the fact that the color scheme of the belt, in three colors, was absolutely consistent throughout.

When his bandages were removed he experimented with various kinds of plastic gimp braiding. He had been quite curious to know how this was done, and thought it would be a good project for his scout troop.

Upon discharge he asked for the names of craft supply houses, discovering that there was one right in his home town, and also for the names of some reference books. It was felt that this was a successful course of O.T. treatment because the patient was kept very busy throughout his hospitalization, improved his manual dexterity, and was given resources to occupy him during his period of convalescence at home.

However, not all O.T. case histories run as smooth a course as this one. The therapist will encounter many problems, both in stimulating and retaining the patient's interest. Here are some principles for approaching and instructing the patient which have been found useful at the Massachusetts Eye and Ear Infirmary.

When approaching the patient for the first time, introduce yourself, shake hands (not too violently) and tell him that his doctor has prescribed occupational therapy as part of his treatment, and that it consists of craft work which he can do while in bed. He will probably reply that he can't do anything while his eyes are bandaged; and the therapist will explain that the O.T. department provides a series of projects which other patients in the same condition have enjoyed and made successfully. This explanation will have to be simplified for patients with language difficulty

to something like: "The doctor wants you to make something with your hands." It is not necessary or desirable to tell the patient that his touch sense is being developed. If he does become curious, tell him that most retina cases receive O.T. routinely because they have to stay in bed for so long, and it will help him to lie still, to which he may reply, "Oh, to keep my mind off my troubles, huh?" It is necessary to judge your patient when deciding how much to say, so that he will neither become worried and apprehensive on one hand, taking it as evidence either that he is going blind, or that he will remain in the hospital indefinitely; or on the other hand refuse lightly what seems to him like busy work because he would rather relax and do nothing.

There is a variety of reasons a patient may give for refusing O.T. treatment. He may say he is too nervous, tired, impatient, or clumsy, or is happy enough just listening to the radio and talking with visitors or other patients. Often he will respond to the suggestion that he could have something to show for his period of hospitalization, and could make gifts for his friends and relatives, and why doesn't he just try *once* to make something. No matter how flat the patient's refusal, keep revisiting him; he may become sufficiently desperate from boredom to try it, or the patient in the next bed who has O.T. may talk him into it.

In instructing these patients, it is important to remember that they are in a sense newly blinded; they have not adjusted to gradual loss of vision as the glaucoma patients have; they are suddenly dependent on their touch sense which they have not heretofore had any reason to develop or use. Even patients who are familiar with handcrafts (and they seem surprisingly infrequent) feel totally incapable of accomplishing anything without using their sight.

As a general rule, first give the patient a finished sample of the treatment medium he is going to use, then hand him the equipment and materials and have him explore them and describe in detail what he finds. Unless the patient seems exceedingly intelligent and enthusiastic, start the project for him: for instance, assemble the first few links of the belt. Be sure you understand exactly how the project is made, and be consistent in the terminology of your directions. It is amazing how many ways one seemingly simple instruction can be logically misconstrued by a patient who cannot see what he is doing; he always seems to interpret "back," "front," "up" and "down" in a manner different from what the therapist intended. Therefore, don't proceed too rapidly; make sure the patient understands one step before explaining the next. Never move the patient's hands and fingers around; unless he makes all the necessary motions voluntarily he will not understand what he is doing. Also avoid rearranging the materials and correcting errors for him. If you must, explain what you are doing and why; but in most cases the patient can do this himself. He will probably make the same mistake again as soon as the therapist's back is turned, and should be prepared to cope with it.

The importance of a pleasant and cheerful voice cannot be overstressed. The blind patient is very sensitive to the tone of a voice, as he has nothing else to go by, and will quickly notice signs of impatience. Speak with a low relaxed voice — just because the patient can't see doesn't mean that he is deaf. If he seems to be getting confused, it is best to have him start the operation from the beginning again instead of continuing from the point that confuses him. If he becomes flustered or nervous (and the therapist must always be on the alert for signs of this), promptly terminate the session and return later in the day. This need not seem discouraging to the patient — merely say that it is too much to learn all at once. Many short, encouraging visits are more beneficial than one long drawn-out one. Never forget to let the patient know when you are leaving him; always say good-bye. This may seem obvious, but occasionally a patient will be seen talking to someone who isn't there, who had thoughtlessly left without saying so.

As for treatment media which a retina patient can do without motion above his shoulder joint, here is a list of projects in their graded order, with adaptations and special teaching techniques for each. It is long enough to keep an average retina case more than busy during his hospitalization unless he has two operations or has had O.T. on a previous admission.

(1) Stringing shoe-button beads is usually not given at all unless the patient has very poor manual dexterity and is unable to start

on a link belt. Require the patient to make a color pattern; place boxes of different colored buttons at various points on the bed. A metal shoelace tip clamped to the end of the elastic facilitates the threading through.

(2) A leather link belt is the usual initial project. Have the patient point out the general shape of a leather link, the rough and smooth sides, and the placement of the holes or slits. Comparing the shape of the double link to a pair of pants is a helpful simile. Once the patient understands the process, he will complete the belt very rapidly, then want to make one for each friend and relative. It is best to hold out on the second belt until the patient has completed a potholder, with which he will have considerably more difficulty.

(3) The Jersey looper potholder is in some ways easier to explain than the link belt, but harder to execute. The patient should ascertain the shape of the frame, and the number of nails along one side. He may use two colors of loopers and keep track of them by putting one set around each wrist. If he makes a second potholder it may be graded in difficulty by requiring a more complicated color scheme and by weaving over and under each separate strand of the looper, instead of in pairs. The patient should not finish off the edge of the potholder except under supervision, because as the second side is completed and the potholder shrinks, the remaining loops will lift themselves off the nails, and a very discouraging mess will result. After finding out how to avoid this, many patients are able to finish them off by themselves.

(4) A woolly yarn dog made by wrapping yarn around a small piece of cardboard and fastening the bunches together in a piece of wire may or may not interest the patient, depending on whether he has young relatives. The patient should memorize the size and number of bunches required, and can make up his own color scheme. When the dog is assembled, he can also clip the loops with blunt scissors, so that the therapist need only give the dog a final trimming.

(5) Knotting with four cords is very adaptable, and may be given as a curtain pull (see illustration), dog leash, or a belt made in three or four separate pieces then braided together. Teaching knotting is a real challenge to devise clear methods of explanation. Practice on yourself first with your eyes closed, giving yourself directions and following them very literally: it can be most illuminating. Patients doing knotting should be visited very frequently until it is certain that they have mastered the process perfectly, since mistakes are hard to fix.

(6) Leather work is probably one of the most appealing of crafts, especially to men, and is most adaptable in the grading scale. It is possible for the patient to punch his own project, if it is pasted together, by using a precision punch. This punch (see illustration), has a guide that keeps the holes the right distance from the edge, and a small spike,

over which the previous hole is fitted, spaces the holes the right distance apart. Always give a practice piece of scrap leather for both punching and lacing: it will be a good indicator of how much the patient should attempt on the project itself. Plastic lacing does not twist as readily as leather lacing. Place a metal shoelace tip on the end of leather lacing.

A patient who has completed this list of activities should have developed a fairly high degree of manual dexterity. After the first few have been completed, the same media may be alternated and the grading still maintained, i.e., lacing leather with the whip stitch and using plastic lacing, knotting a curtain pull, lacing leather with the single or double buttonhole stitch, and knotting a twelve-strand belt. The therapist will have to use her judgment in what she expects from the patient, and how fast to push him. Once discouragement has set in, it is very hard to overcome, but as far as possible the therapist should leave the patient able to proceed independently until the next visit.

The successful completion of even one project does wonders for the morale of a sightless patient. It is a most rewarding experience for the therapist to watch this unfolding of ability in a patient who hadn't believed himself capable of accomplishing anything, and his complete amazement at what he could do once he really tried. Few patients are more verbal in their appreciation for the way O.T. helps them, how much better they feel while they are busy, and how much easier it is to lie still. As for the unfortunate cases who do not regain their vision, their rehabilitation has already begun.

The author hopes that this article will be of assistance to therapists in general and other hospitals who have patients who are in addition blind, and that it will interest more therapists and students in work in this challenging and fascinating field.

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Studies of Technique and Effectiveness of Ward Occupational Therapy

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At the Boston Psychopathic Hospital a program of ward occupational therapy is carried out on the acute and admission wards and is especially directed to those patients whose conduct is most disturbed. This is based on the general concept that behavior disorders in the psychiatric sick stem from fear and distress and with good social and occupational treatment can be beneficially modified. This program is intended to improve the social interrelationships of the patients, to put them at ease and to stimulate interest in as wide a variety of activities as possible.

The effectiveness of this program is evaluated here on a concrete basis. It shows the success of the occupational therapist and other personnel in interesting otherwise apathetic, overactive and disturbing patients and in bringing about social interactions in previously unsocialized patients. A series of observations were made during several occupational therapy periods on the acute male ward and translated graphically into charts. Techniques used by the therapist could be studied objectively (1) by comparing the different therapeutic tools as to their ability to interest patients, (2) by describing the therapist's method of approach on various occasions and the resulting motivation

of formerly inactive or overactive patients, and (3) by comparing the effectiveness of a trained worker with that of an unskilled worker (an undergraduate sociology student). A distinction is made between (1) those patients who were activated merely by having games and activities available; (2) those who could be stimulated by any member of the personnel; and (3) those who required the persistent efforts of the therapist.

Only through objective descriptions and portrayal of activities was it possible to compile significant data. The presentation of the observational technique is itself considered worthwhile as there has been little application of such techniques to occupational therapy. It should be a valuable aid in teaching occupational therapists, recreational leaders and other members of hospital personnel.

METHOD

The method consists of the following:

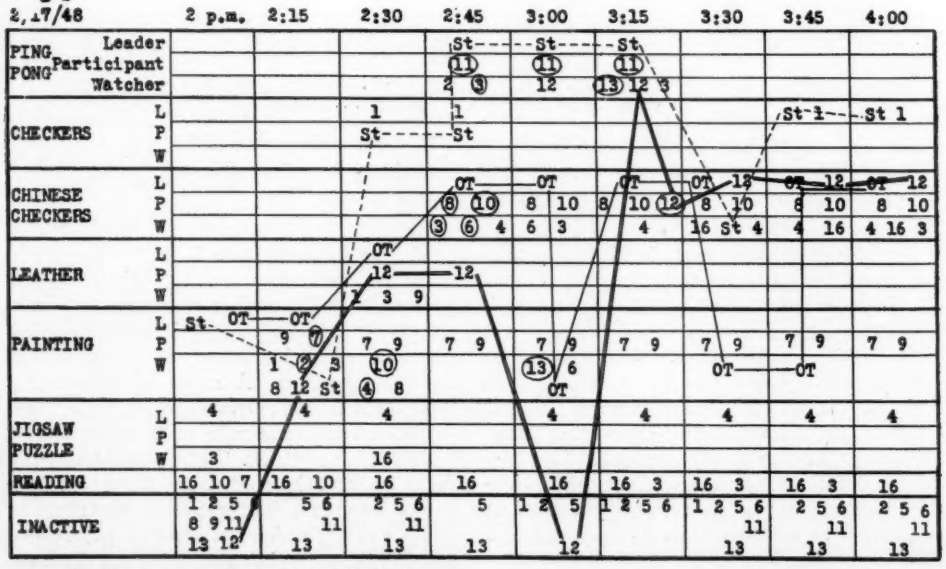
1. An activity-participation chart to portray who introduced and played a leadership role in all activities, the shift of patients from one activity to another and their degree of participation.
2. A running description of all stages of participation.

A description of four sessions of ward occupational therapy upon the same acute male ward is presented here. The first (February 17, 1948) is presented in some detail, and the remaining three are summarized. Because of a fairly rapid turnover of patients on this ward, these four observations tend to demonstrate a variety of ward occupational therapy experience.

February 17, 1948 (Chart 1)

The occupational therapist and student entered and observed the geographical distribution of patients in the ward. Seven patients were sitting or standing in the smoking room where the radio was playing popular music. None of these patients was observed talking to another at the time. In the dormitory room there were three patients (4, 16, 3): 4 doing a jig-saw puzzle; 16 reading the newspaper; 3 watching the puzzle. Patient 5 sat in the hall

CHART 1



○ Patient motivated by O.T. or student

outside the kitchen making contact with no one. Patient 13 was standing in the back hall, looking at the floor and occasionally muttering to himself. Two patients (6 and 7) were sitting at the table in the back alcove; patient 7 was reading the papers.

Available for any patient were pingpong, checkers, Chinese checkers, cards, two puzzles, a few books and many magazines.

The illustration is an activity chart of the main events observed by the therapist during the two-hour period.

While the student and therapist were sitting up painting materials in the smoking room, several patients (1, 2, 3, 8, 9, 12) watched and seemed curious. Patient 9 said "Gee, I'd like to do some of that." He was given the brushes and paints and started work. Patient 7 was told, "Come in if you would like to paint." He said nothing but came in, sat down, and concentrated on painting throughout the whole period. Patients 7 and 9 worked steadily and rarely spoke to each other.

The therapist then brought out leather projects while 1, 3, and 9 watched. Patient 12 was angrily talking to himself ("Damn the veterans' hospital and the doctors!") and, without further comment, picked up an unfinished comb case; 1, 3, and 9, saying nothing, watched him begin. Patient 9 then returned to his painting.

Patient 1 asked if he could "have a job." When asked, "What do you have in mind?", he suggested checkers and played with the student.

Patient 5 was asked if he was interested in the activities going on, but he shook his head in response preferring to remain sitting in the hall. Patient 4 stopped working on his puzzle to come over at the suggestion of the therapist and "see what the others were painting." Then he returned to his puzzle. Patient 16 watched 4 at the puzzle, making a few kibitzing comments, and then resumed his newspaper reading. The therapist then set up a game of Chinese checkers in the ward and asked patients 3, 6, 8 and 10, 'How about a game of checkers with me?" They came over to observe what it was and to see who was going to play; 8, 10 and the therapist played one game. Patient 4 watched for a while and returned to his puzzle; occasionally he looked up to comment about the game to the therapist, saying, "That's a pretty good game — confusing when too many play" and "I used to play it when I was a kid." 6 watched and then returned to the smoking room to watch the painting for a while. Later he resumed sitting in the smoking room and apparently paid no attention to the other activities.

Patient 12 (General Paresis) finished his comb case and started restlessly walking up and down the room, holding his head, shouting and talking.

Meanwhile, the student finished a checkers game with 1 and said to 11, "How about playing a game of pingpong?" They started to play; patient 2 watched silently for a while and later paid no more attention, as he lay down on a bench. Patient 3 watched the pingpong game; when the therapist asked him again if he would like to join in the second game of Chinese checkers, he shook his head saying, "No thanks — that's kid stuff," but stayed to watch. Patient 13 was urged to "Get some exercise and join the pingpong," but he did not feel like it. He watched for awhile and then stayed in a corner of the smoking room. Patient 12 stopped pacing around the ward for a few minutes to watch the pingpong. The therapist, seeing that 12 had momentarily quieted down from his almost constant walking, talking and shouting, invited him to join a second Chinese checkers game. He immediately sat down with the therapist and 8 and 10, and took the leadership in directing whose move was next and who did not play correctly. Thus, he was enabled to use his energy and aggression in a more satisfying manner. Patient 16 stopped reading the papers to watch the game; he made no comment but smiled occasionally at the therapist.

Patient 11 returned to his chair beside the radio when his pingpong game was finished. The student then played another game of checkers with 1.

CONCLUSIONS

The introduction of an occupational therapist and a student to the ward brought about marked changes in the social situation. At first, the patients were scattered around the ward making no contact with each other and, with the exception of four patients (who were reading or doing a puzzle) and the few who

might have been listening to the radio, seemed uninterested in their environment and its opportunities. During the period, thirteen of the fourteen patients participated actively or were interested in the five games and two crafts offered. Their interest was aroused spontaneously or by an active welcome from the therapist.

The diagnoses and brief behavioral description of these patients are as follows:

1. General Paresis—stubborn, aggresive, playful
2. Dementia Praecox-Catatonic — 5 months post-lobotomy, many somatic complaints, quiet, unsociable
3. Senile Psychosis—quiet, spends most of time reading
4. Without Psychosis-Behavior Disorder — quiet, friendly when approached, shy
5. Senile Psychosis-Simple Deterioration—withdrawn, sits alone
6. Without Psychosis-Alcoholism — quiet, stays by himself
7. Without Psychosis-Psychopathic Personality — usually reading, curious about other patients, quiet
8. Psychoneurosis-Obsessive Compulsive — 11 days post-lobotomy, talkative, critical of other patients, interested in surroundings
9. Early Schizophrenia with Depression — tense, tearful, uncommunicative
10. Alcoholic Psychosis with Chronic Hallucinosis — 4 days post-lobotomy, pleasant, lethargic, confused
11. Psychosis with Other Brain and Nervous Disease —friendly when approached, shy, sits in corner, watches other activities
12. General Paresis—restless, noisy, constant pacing and talking
13. Manic Depressive-Mixed — 40 days post-lobotomy, stays alone and talks to himself, watches others
16. Without Psychosis-Psychopathic Personality — usually reading or playing cards.

The number of patients (twelve) mobilized by the therapist compared to the number (six) mobilized by the sociology student is in indication of the greater facility of trained personnel in manipulating the ward situation. It is to be noticed that no games or activities (except a puzzle and reading) were started spontaneously by the patients without the assistance of personnel on this occasion.

The progress of patient 12 (General Paresis) has been charted with a solid black line. It is seen that he was at first inactive and then watched while the therapist brought out painting materials. As this patient was almost constantly talking to himself, shouting and walking around the ward and disturbing the other patients, the therapist tried to channel his activity into the occupational therapy program. The therapist brought out leather projects and the patient selected a small leather comb case to lace; this occupation quieted him and absorbed his interest for about half an hour, freeing the therapist to start other patients (8 and 19) in a Chinese checkers game. When patient 12 finished the comb case he again started moving restlessly around the ward until the therapist brought him into the game. He was taught how to play and then became a leader in this social situation. Chart 1 describes graphically the activities and interrelationships brought about by the workers in a form that can be easily understood. The progress of any patient can be followed through the period, as with patient 12, by lines connecting his various positions in activity.

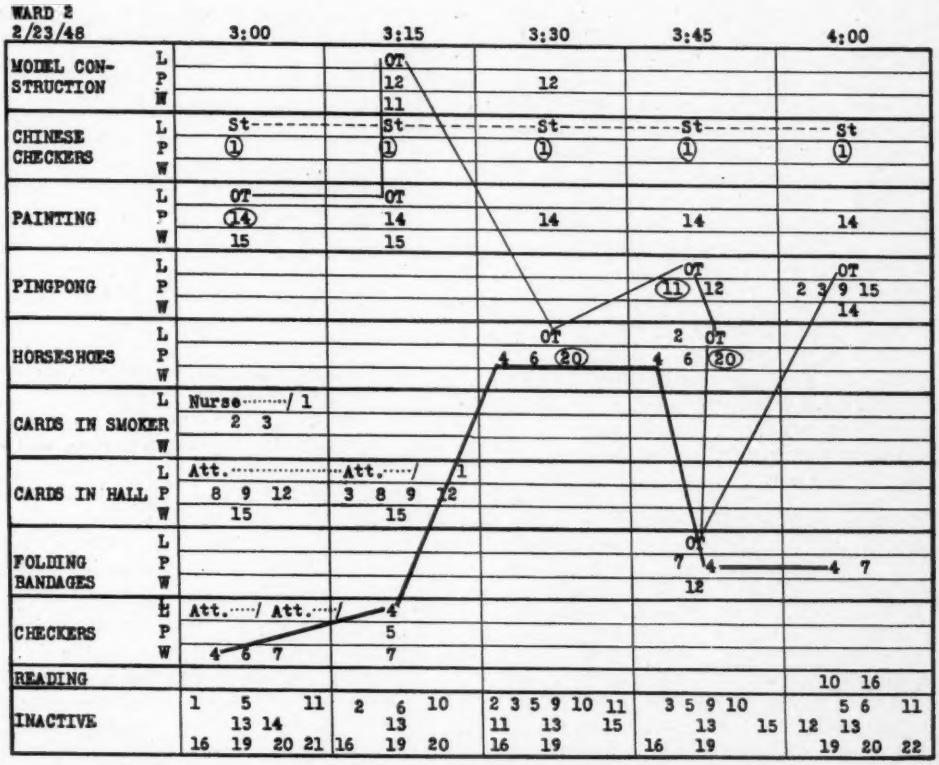
At the end of the period, nine of the patients were more or less interested in the activities at two tables (checkers, painting, Chinese checkers). Two patients were chatting together, and two had returned to an apparently uninterested status. In all, nine patients had been drawn temporarily from an inactive situation and were showing some degree of interest or participation in the occupational therapy opportunities offered to them.

February 23, 1948 (Chart 2)

At the beginning of this period of observation there were two attendants playing checkers with three patients watching the game. When the attendants left, one of the patients (4) who had been watching, persuaded another patient (5) to start a game with him. Although the personnel is asked not to play games with each other, in this case the attendants' game seems to have been the inspiration for the patients starting their own game.

On the other hand, when the nurse and attendant who were playing cards with the patients were called away by other duties, the activities stopped completely. It has been noticed generally in these observations that, although these employees are not trained in leading recreational activities, their ability to

CHART 2



·····/ Person leaves ○ Motivated by O.T. or student

increase the ward's social realtionships is important. (All activities during this period of observation were initiated or inspired by personnel.)

This chart indicates clearly the ability of the therapist to shift around and direct eleven patients in a total of five activities during the period, whereas the untrained student seemed to be unable to extricate himself from a one-hour checkers game with the same patient. (Unfortunately the student had asked a patient with an organic brain condition to play checkers; the patient was almost entirely unable to play such a complicated game.)

The patients may be described as follows:

1. Organic Brain Disease — friendly, quiet, shy, sits alone but watches ward activities
2. Primary Behavior Disorder-Conduct Disturbance — lively, sociable, active
3. General Paresis — aggressive, stubborn, playful
4. Dementia Praecox-Hebephrenic — stays alone but friendly, quiet
5. Dementia Praecox-Catatonic — 5 months post-lobotomy, quiet, friendly, shy
6. Dementia Praecox-Catatonic — 5 months post-lobotomy, watches others, quiet, reads
7. Alcoholic Psychosis with Chronic Hallucinosis — 10 days post-lobotomy, pleasant, lethargic, friendly, docile
8. Manic Depressive-Circular — sociable, friendly, talkative, active
9. Dementia Praecox-Catatonic — tense, sociable, usually reading or playing cards
10. Senile Psychosis — quiet, usually reading
11. Acute Schizophrenic Turmoil — confused, quiet, restless
12. Post-traumatic Psychosis — sociable, talkative
13. Without Psychosis-Presenile Arteriosclerosis — usually reading, watches other patients, stays by himself

14. Dementia Praecox-Paranoid — tense, tearful, stays alone, withdrawn
15. Dementia Praecox-Catatonic — 5 months post-lobotomy, many somatic complaints, sociable
16. General Paresis — noisy, constant pacing and shouting
19. Psychoneurosis-Anxiety — stays alone, talkative
20. Dementia Praecox-Paranoid — pleasant but stays by himself, gestures and mutters to himself
21. Undiagnosed Psychosis — quiet, usually reading
22. Psychoneurosis-Obsessive Compulsive — 17 days post-lobotomy, talkative, slow moving, critical of other patients, jokes

Patient 4 (Dementia Praecox-Hebephrenic) engaged in three activities (checkers, horseshoes, folding bandages), each of which was initiated by personnel. Being an excellent checkers player, he needed no direction in this situation. When once started on an occupation he carried on independently for awhile, but he seemed to need the initial stimulus of some one else.

March 8, 1948 (Chart 3)

During this period there was a continuous game of cards in the hall of the ward among five patients (8, 10, 14, 15 and 24); all were cases sent in to the hospital by the court. As these cases are considered primarily a diagnostic rather than a therapeutic problem, they are not specifically included in the occupational therapy program (unless so directed by the doctor). However, their presence upon the ward naturally affects the general ward atmosphere. These patients were able to carry out their own activities with the available facilities, while the therapist concentrated on those patients who would be expected to benefit most from skilled direction. Seven patients were motivated by the therapist in four activities; these were 1, 3, 6, 9, 11, 12 and 13.

The group consisted of the following patients:

1. Dementia Praecox-Paranoid — withdrawn, usually trying to sleep
2. Manic Depressive-Mixed — pacing rapidly up and down hall, self-preoccupied
3. Psychoneurosis-Aaxiety — sits alone, many somatic complaints, likes to talk about troubles
4. Paranoid Condition — friendly, inquisitive, but stayed by himself (probably because of language difficulty)
5. Without Psychosis-Psychopathic Personality with Pathological Sexuality — quiet, sullen, interested in other patients
6. Manic Depressive-Mixed—restless, confused, noisy, angry
7. Without Psychosis-Psychopathic Personality with Pathological Sexuality — plays cards or reads
8. Without Psychosis-Psychopathic Personality — sociable, plays cards
9. Dementia Praecox-Catatonic — 4 months post-lobotomy, quiet, pleasant, stays by himself, friendly
10. Alcoholic Psychosis-Other Types—friendly, alert, plays cards
11. Dementia Praecox-Catatonic — sociable, friendly, interested in ward activities, cooperative
12. Dementia Praecox-Catatonic — 5 months post-lobotomy, quiet, reads or sits alone
13. Dementia Praecox-Catatonic — 5 months post-lobotomy, friendly, quiet
14. Dementia Praecox-Paranoid — sociable, talkative, usually plays cards
15. Without Psychosis-Psychopathic Personality with Pathological Sexuality — quiet, watches ward activities
21. Dementia Praecox-Paranoid — quiet, stays by himself
24. Without Psychosis-Psychopathic Personality with Pathological Sexuality — cooperative, sociable, talkative.

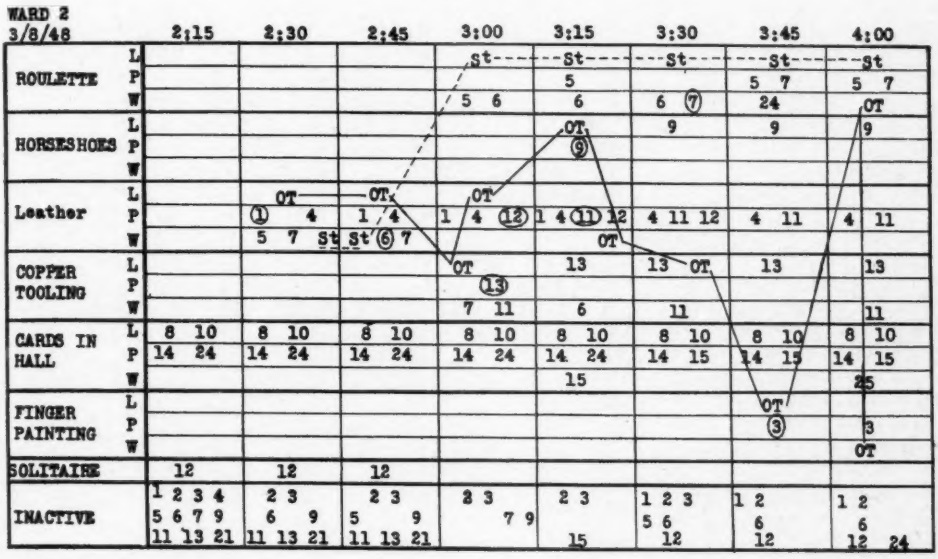
It is seen that the therapist directed and organized the ward activities until near the end of the period; then, when most of the patients were sufficiently interested to carry on their occupations, the therapist was free to study one patient's (3) reactions to his finger paintings and observe the activities in the rest of the ward without taking part in them.

The interest of the patients (1, 4, 11, and 12) in leather work was well sustained during the afternoon. It is important in increasing ward activity that the therapist be able to select activities which the patients will continue without help and supervision.

Patient 3 (Psychoneurosis-Anxiety) presents an interesting situation in the therapist's selection of activities for the individual patient. This was a patient very much concerned with his somatic symptoms. Formerly he had refused all occupational therapy participation because he had to "control his breathing so he wouldn't drop dead." The therapist talked with him for awhile, listening to the patient say how many doctors he had seen and how many tests he had taken. The therapist steered the conversation around to the Rorschach test and to the similarities between

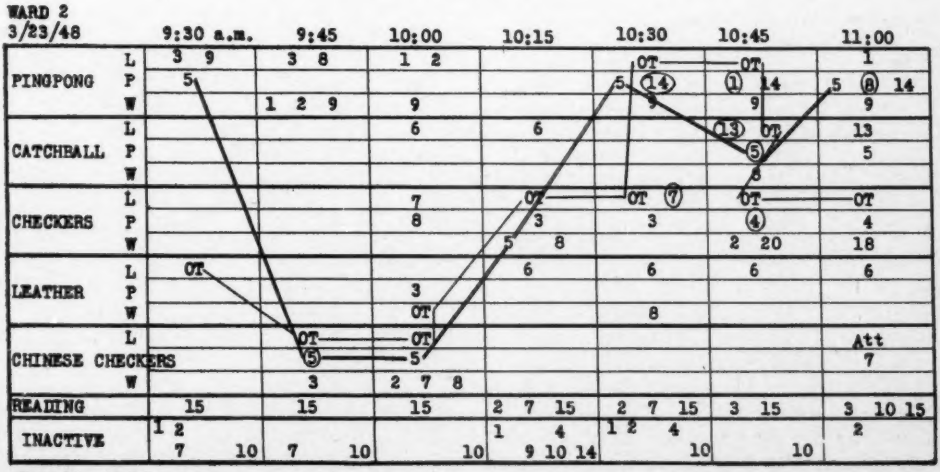
interpreting this and studying fingerpainting. The patient then said he'd like to do some fingerpainting "as long as it was considered as a sort of a test." This is a good example of how the therapist can attempt to channel a patient's interest into an agreeable activity which to the patient meant a combination of special treatment and recreation.

CHART 3



○ Motivated by O.T.

CHART 4



○ Motivated by O.T.

March 23, 1948 (Chart 4)

As in previous observations, but here presented more graphically, is the gradual build-up of the therapist's ability to motivate patients throughout the period in five activities: first half hour (0); second half hour (1); third half hour (2); fourth half hour (5). The beginning of the period is spent in contacting patients, getting acquainted with new arrivals, and laying out materials.

These patients are characterized as follows:

1. Without Psychosis-Psychopathic Personality — alert, sociable
2. Without Psychosis-Chronic Alcoholism — alert, friendly, active
3. Undetermined Psychosis — sociable, friendly, lively
4. Manic Depressive-Mixed — withdrawn, slow moving
5. Acute Schizophrenic Turmoil — confused, restless, talkative
6. Dementia Praecox-Paranoid — 19 days post-lobotomy, pleasant, independent
7. Dementia Praecox-Hebephrenic — 19 days post-lobotomy, friendly, curious, sits alone or reads
8. Without Psychosis-Mental Deficiency — aggressive, active, very sociable
9. Dementia Praecox-Catatonic — 4 months post-lobotomy, pleasant, quiet, docile, stays by himself
10. Dementia Praecox-Paranoid — withdrawn, uncommunicative, sits and stares, occasionally reads
13. Schizophrenia in remission — 13 days post-lobotomy, pleasant, lazy, irresponsible (in O.T. department during morning)
14. Dementia Praecox-Catatonic — sociable but tense (in O.T. department during morning)
15. Dementia Praecox-Catatonic — uncommunicative, reads constantly

Patient 5 was kept quite close to the therapist during the period in order to prevent his disturbing the others. He was in an extremely confused, restless state and was consistently interfering with the activities of the other patients or personnel. The nursing service had asked that he be kept busy and out of trouble, so as soon as possible the therapist asked him if he would like to play Chinese checkers. The patient said "Sure, no one else has asked me to"; he seemed pleased to receive the attention and to have something definite to do. (He also seemed to think the therapist was his girl friend "Bunny.") The game was a thoroughly disorganized one and later the patient followed the therapist around the rest of the morning, first watching a game of checkers and then taking part in a pingpong game. As his confused behavior annoyed the other pingpong players, the therapist asked patient 13 to play catch with him. At the end of the period he was alternately playing catchball and swinging wildly at the pingpong ball.

Patient 6 (Dementia Praecox-Paranoid, 19 days post-lobotomy) entered the smoking room by himself, played ball alone, and later picked up a leather cigarette case and worked on it without any help. The amount of initiative shown here was a little unusual for a post-lobotomy patient.

Patient 9 (Dementia Praecox-Catatonic, 4 months post-lobotomy) was playing pingpong at the beginning of the period. When others entered the game, he gave up his activity and watched them. However, when the game stopped he made no effort to start another or to become interested in any of the other patients or their activities. He remained sitting in the smoking room, doing nothing, until another game was started by the therapist; he watched this with interest. Unlike the independent patient 6, this post-lobotomy case is inclined to be anergic, needing direction or an invitation in order to be included in the ward's social activities. Although the patient was found playing at the beginning of the observation, it is likely that patient 3 (an active, friendly boy) had started the game; then 3 discovered that 9 was not a very good player and asked 8 (another young, energetic patient) to play instead.

RESULTS

This study has shown that it is possible to carry out a successful occupational therapy program on the wards using a variety of games and crafts. Some of the activities which interest patients were determined. The greater effectiveness of the occupational therapists in directing these activities compared to that of other members of the hospital personnel was evident. It has been found that the spontaneous reactions of the patients, as expressed by their activities, is increased by the presence of personnel or other workers. Although most of the games (cards, checkers, pingpong, Chinese checkers, puzzles) have been available at any time on the ward, a great many of the

patients seemed dependent on the stimulus of some staff member or else they remained socially inactive.

These observations make it possible to measure the progress of the patient's illness. Patient 20 on 2/3/48 (Dementia Praecox-Paranoid with Alcoholic Psychosis) was inactive until the therapist persuaded him to play horseshoes. On 3/4/48 the patient had a bilateral prefrontal lobotomy and it is noticed he was independently active on 3/23/48 (as patient 6 on chart) when he wandered in and did leather work and played catchball without any direction from the therapist. This was a definite advance in the patient's ability to take advantage of the recreational opportunities of his environment.

Although these are the patients who are generally too disturbed to be taken up to the occupational therapy department, the recorded observations have shown that they are able to respond to various activities and to form social groupings centered around certain situations. That these patients can be motivated by an occupational therapy program means that the introduction of such a plan of activities to their ward has been a valuable and an effective one.

DISCUSSION

This method of observation should prove most useful in a psychiatric hospital where the increase of patient socialization is desirable. In a general hospital program a technique of study is valuable in order to organize the department in the most efficient and functional manner possible. For example, by recording the general gravitation of the patients toward each craft, it could be determined whether more floor space and equipment should be allotted for the carpentry or for the ceramics section in a large diversified program.

As a tool for teaching, these charts can be used for instructing the inexperience student; the trained therapist often unconsciously knows how to manipulate a group of patients but may be unable to translate the methods used to the unskilled worker. The chart of 2/23/48 illustrates this lack of mobility on the part of the student compared to the greater motivating ability of the therapist. A demonstration of the chart with discussion was a great help toward educating the student.

There has long been a need for an objective method of evaluating the results of an occupational therapy program in order to determine the response of the patients, the effectiveness of the individual therapist or worker and the therapeutic tools most suitable to the situation. The program discussed here could be evaluated and demonstrated only by using such a method of observation to determine its effectiveness.

SUMMARY

Four observations of occupational therapy periods in an acute male ward were recorded. The charts are presented and interpreted. They show that:

1. An occupational therapy program is effective for patients too ill to be included in the regular department activities;
2. A therapist is much more skillful than untrained ward workers in manipulating ward socialization, although the presence of any member of the personnel is a stimulus to the patients;
3. A patient's progress may be objectively recorded during a certain period or from day to day.

The objective method of observation and portrayal in an activity participation chart is a technique which may be used:

1. To teach inexperienced therapists or recreational leaders;
2. As a means of organizing a general occupational therapy department;
3. To measure the effectiveness of an individual therapist or of an occupational therapy program;
4. To demonstrate some of the methods and activities which are used.

Visual Communication for the Hearing Handicapped

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Hearing inacuity has long been recognized as a handicap to successful communication in the educational, economic, and social worlds. The degree to which communication may be impeded depends upon the type and severity of the hearing deficiency and upon the age of onset.

In all cases of hearing impairment the otologist's diagnosis should be sought, and suggested therapy accurately and completely followed.

For the adult patient the therapy program may include:

1. Otological examination and treatment,
2. Acoustic stimulation and amplification by means of a mechanical hearing aid,
3. Instruction in visual speech comprehension (visual hearing, lip reading, etc.)
4. Speech rehabilitation to assist in the retention of normal voice quality and distinct articulation.

The hearing status of the congenitally deaf child should be ascertained at the earliest possible moment following birth. The parents should have expert guidance in the child's early infancy care with emphasis on:

1. Correct methods of accustoming the child, from the very first, to watch for visible speech clues in place of the usual auditory clues of the normal hearing baby,
2. Correct discipline routine with the objective of laying proper foundation for future education and social adjustment.

Further needs of the congenitally deaf child include:

1. Correct school placement in a strictly oral environment,
2. The development of as normal speech and voice as possible, by approved acoustic, visual, and tactile methods,
3. Acoustic stimulation and training of even the slightest degree of residual hearing,
4. Occupational guidance to prepare the congenitally deaf child to take his place in a hearing world,
5. Proper mental attitude toward his hearing handicap and personality adjustment to the problems growing out of his need to conform his mode of life, to that of his hearing relatives and friends,
6. Instruction in visual speech comprehension, so as to enable him to communicate with persons of normal hearing.

The educational program for the hypacusic child (hard of hearing) is, to a certain extent governed by the degree to which the hearing deficiency becomes a handicap to his educational progress and social adjustment. Special classes in public and private schools provide a full program for the child whose hearing inacuity retards his progress in regular classes.

It is highly advantageous to the child with a slight hearing loss to continue his school work in the regular classes and to be given a supplementary program including:

1. Instruction in visual speech comprehension,
2. Acoustic stimulation and amplification (hearing aid),
3. Speech correction and voice training,
4. Occupational guidance,
5. Psychological counselling in personality adjustment.

While it is true that hearing inacuity renders communication difficult, we do not wholly depend upon the ear to put us in touch with other human beings. It has been estimated that between thirty and sixty per cent of what we hear depends upon visual perception. At least partial support of this statement may be found in the fact that in any auditorium, lecture-room or banquet hall an audience may be observed shifting its position so as to see the speaker. The light in the speaker's eye, the rapid interplay of facial muscles giving emotional expression to the countenance are for

the normal hearing person, both an auditory and a visual clue. For the hearing handicapped it becomes, according to the degree of impairment, a partial or complete visual process.

The individual with reduced or negligible hearing acuity may be said to receive spoken sound sensations over the visual pathways. Therefore it may also be said that when the "eye" functions instead of the "ear," a visual comprehension of spoken thought becomes a substitute for that which is normally achieved through hearing. The term "Visual Hearing" therefore seems to express more or less adequately what an acoustically handicapped person does when "he listens with his eyes."

"Visual Hearing" is therefore the term given to the method of instruction in Visual speech comprehension originated by the speaker, in the Phoneties Research division of the Speech Department of Ohio State University, in September, 1930.[1]

Visual Hearing may be defined as the comprehension of spoken thought by means of visual stimuli, when auditory stimuli fail to function, either wholly or in part. It is the alert visual perception of the labial, lingual, mandibular, facial and external laryngeal movement which make up speech sounds, and the quick and accurate recognition and translation of these kinaesthetic movements, into word patterns which evoke mental concepts. It is used in place of "Speech Reading" or of an older term "Lip Reading."

Visual Hearing is an educative process featuring instruction by means of silent motion pictures. This instruction is accomplished through a complete sequence of films in which various speakers are photographed as they give vocal utterance, to subject matter designed to constitute a logical and complete teaching procedure. These cinnematographic instruction films units, pictorially present all English vowels and consonants, in their varied phonetic forms and in their normal assimilations in spoken discourse.

Each instruction unit is photographed on one hundred foot 16mm. film lengths. A complete assignment in itself, each successive unit follows a logical instruction sequence. Each one hundred foot film assignment comprises three parts:

1. The first part which is intended to serve as a text, announces the assigned topic and shows several title cards bearing printed examples of sentences previous to their utterance by the speaker.
2. The second part shows the speaker speaking the remainder of the assignment, with no printed clues to aid the student in his translation.
3. The third part contains questions which the student must answer from his visual interpretation of the speaker's visible speech manifestations, the correct translation of which discloses the particular phonetic theory involved.

The Visual Hearing Method is a laboratory instruction technique, in which the student is required to project a specific film assignment on a silent motion-picture screen, and from his visual interpretation of a speaker's work make his own analysis of the visible appearance of speech sounds as they actually occur in normal speech situations, rather than in static isolated instances. In other words the student by his own deductive power observes and determines characteristics which visibly differentiate one consonant or vowel from another, one group of words from another similar group, and one facial muscular pattern which indicates the speaker's particular emotion rather than another.

Expert skill in comprehending speech visually depends upon thorough knowledge of the physiological and phonetic aspects of speech sounds, upon a mastery of vocabulary and appreciation of meaning, and upon alert observation, quick association of ideas and abundant visual memory. Acquisition of this skill to its fullest degree can come only with thorough instruction and great personal effort on the part of the student. While it is true that some deafened individuals hear visually without apparent training, it is likewise true that in practically every case their performance is at times inconsistent, often inaccurate and usually limited in scope.

The educational characteristics of the Visual Hearing Method follow learning principles

[1]Term suggested by G. Oscar Russell, PhD., who also directed the early photographic work.

which are basically sound. One important objective aims to encourage the student to "learn by doing." Observing a speaker on a screen, the student learns to depend wholly upon his own skill in visually interpreting what is said.

With this objective in mind, the Visual Hearing Method[2] was inaugurated by the author as a laboratory technique in the Phonetic Laboratories of the Ohio State University, in September of 1930. It was originated for the purpose of instructing in visual speech comprehension large numbers of University Students with varying degrees of hearing deficiency. By this method the student is required to spend one 50-minute daily period in the motion picture laboratory. The completed film assignments are then discussed in class, corrections made, and the phonetic principles on which each film is based, outlined and analyzed. Between 1930 and the present time over two thousand students have been taught by this method.

Briefly stated, some of the more significant educational characteristics of the Visual Hearing Method include the following:

1. *It is objective.*
   By employing a silent motion picture of a speaker, this method provides, in teaching and testing of visual speech comprehension, control of the following factors:
   (a) the constancy of speech movements,
   (b) the visibility of speech presentation,
   (c) the degree of distance from the sound source,
   (d) the rate of a speaker's diction.
2. *It is practical.*
   By setting up a laboratory technique the motion picture method tends to lighten the educational staff load:
   (a) by providing instruction to large groups of children and adults where limited funds prevent the appointment of a sufficient number of teachers,
   (b) by furnishing these students with ample laboratory drill which does not require the services of a teacher,
   (c) by supplying added drill to the slow student, thus encouraging him to greater achievement,
   (d) by challenging the efficient student to set his own progress,
   (e) by accustoming all students at the start to all types of speakers,
   (f) by conserving the energies of the teacher for more important pedagogic and administrative duties.
3. *It has educational value.*
   The student is assigned a task to be accomplished by personal effort and at his own speed. The use of the motion picture technique has educational advantages in that:
   (a) it promotes greater accuracy of performance in students with some degree of residual hearing by banishing for them the possibility of being helped by hearing some of the sibilant and fricative speech sounds, for example, s, z, sh, ch, and j,
   (b) it discourages a strained effort to hear and therefore makes for more concentrated attention on the actual visual speech movement patterns,
   (c) it increases accuracy by discouraging a tendency to "guess" at what is said,
   (d) it tends to enrich the synthetic powers of the stduent by encouraging accuracy without developing an over-analytical attitude,
   (e) by reason of its deductive approach it avoids conditioning the student to any fixed response. No attempt is made for example, to attribute to any vowel or consonant any specific visible characteristic.
   (f) in the present emphasis on visual education in all branches of learning, the Visual Hearing Films would seem to present a significant approach to the education of the acoustically handicapped.
4. *It is psychologically sound.*
   By individualizing the student's instruction, teaching visual comprehension of spoken thought through motion-pictures tends:
   (a) to overcome in the slow student a tendency toward an inferiority complex,
   (b) to encourage the slow student to group participation by confidence gained from laboratory drill planned to meet his need,

[2]This work was begun at the suggestion of G. Oscar Russell, PhD., at the time of Phonetics Laboratories.

(c) to discourage a feeling of superiority on the part of the gifted student, by keeping him busy at work which will challenge his greatest effort.

Experience in using the Visual Hearing Films, since 1930, points to the need of this form of visual education on all instruction levels. Anticipating this need and convinced of the potentialities of visual instruction through pictures, the speaker's research (since 1930) has been directed to supplying motion-picture instruction units on several educational levels.

Visual Hearing Motion Picture films in use since 1930 in the speaker's classes of hard-of-hearing university students, and as experiments under her direction in classes for children with defective hearing includes the following series:

1. *Visual Hearing Film Series I*

Complete instruction sequence in thirty film assignments (originated for university students) (as above described).

This entire series has been revised and rephotographed during the summer university quarter (1947), and Winter Quarter (1948). These films are in technicolor and together with an instruction manual will be ready for distribution in late summer (1948).

2. *Visual Hearing Films Series II*

Complete instruction sequence in thirty film assignments applicable to the intelligence level of hard-of-hearing children (ages seven to fourteen years) approximately, based on same phonetic principles as in Series I. A variety of speaker subjects both adults and children are photographed as they speak the lesson content. (Under revision with possibility of distribution at an early date).

3. *Visual Hearing Film Tests*

In this series are grouped various types of test films on each education level, ranging from test of a pre-school deaf child's visual hearing ability to that of a mature adult. The test materials cover the phases of a student's ability in the following areas:

(a) Accurate verbatim translation of a speaker's words,
(b) Ideational content,
(c) Power of synthesis,
(d) Alert discrimination,
(e) Quick association of ideas,
(f) Visual memory span.

While the Visual Hearing Method of instruction by means of a silent motion picture films is a complete educational sequence which sets up definite objectives differing to some extent from those of other methods, there is nothing of a purely controversial nature to prevent its use by the exponents of all existing methods. Its laboratory method of approach renders it advantageous in the following situations:

1. as a supplement to any other educational method,
2. as an enriched cultural program for the gifted student,
3. as added drill for the slow student,
4. where there is limited educational staff,
5. in the educational therapy program for hospitalized patients:
   Army Hospital Program
   Navy Hospital Program
   Veteran Rehabilitation Program
   Occupational Therapy Program
6. for home study in the case of the aged or other hearing handicapped individuals living in communities too far distant from educational centers.

Read at the Annual Meeting of the Ohio Occupational Therapy Association, 1948.

* * * * *

Note:

1. Demonstration of Visual Hearing Films followed the paper. Practical application of the theory of this method was shown in the ease and fluency with which a student visually comprehended a story spoken by Miss Mason without voice.

2. Reason for the adoption of the term "Visual Hearing" rather than "Lip-reading" was explained by Miss Mason and demonstrated to the audience by the same student's skill in visually understanding a silently spoken sentence with the speaker's lips completely covered.

(Reported by a spectator)

The Student Occupational Therapist

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Upon entering a new educational experience, a student has the desire for a well laid out concrete path to follow. Psychologically this is understandable. Knowledge of facts helps to eliminate feelings of insecurity, whether one be a student starting on a new affiliation or a registered therapist entering a new position. The path can be routed by the director of the school, in the form of a factual statement concerning her new venture. This form should include the following information:

SUGGESTED FORM

Name of Institution **Location**
Directions for reaching the Institution:
Bus, train, subway, walking distance from residence. Cost of carfare per day.
Dates of training **From** ..... **To** .....
Working hours of the Occupational Therapy Dept.
Name of Clinical Director
Institutional Address of Clinical Director
Telephone Number
Home Address of Clinical Director
Telephone Number
Students should contact the Clinical Director at the Institutional address three (3) weeks before starting her affiliation.
Student residence If provided or arranged for
Name and address of residence
Telephone number
Directions for reaching residence
Bus, subway, walking distance from railroad. Cost.
Cost of room **Paid to**
Approximate cost of meals in that area
Students should contact the individual in charge of the residence two (2) weeks in advance and notify her of the day and hour of her arrival.

If there are any stipulated rules or policies related to the residence, they should be added to this form. One copy provided by the individual in charge of the residence eliminates any infringement of set policies. If full or partial maintenance is provided, this should be included in the form.

The information for this form can be obtained from each clinical director by the educational director and then passed on to the student at a designated time. This method eliminates many uncertainties and gives the student a feeling of direction and security in her new undertaking. To the clinical director it means the elimination of additional paper work in answering miscellaneous and sometimes misguided questions. Ohio State University, for one, uses a form similar to the one suggested. A comparative study by this clinical director has shown that Ohio State University students face fewer obstacles and misunderstandings concerning their assignments, than do students who have received a lesser amount of previous information.

The first step in clinical training is thus well planted for the student's direction. The second step is then taken by the clinical director who, by means of a brochure, orients the student to her new surroundings. The value of such booklets was evident in the programs of the Army and Navy in familiarizing the G.I. with the functions and facilities of their hospitals. This booklet should answer the following questions for the students:

What is the purpose of the whole program?

What part is played by the occupational therapy program?

What is the lay-out of the physical plant?

Who are the members of the staff and their titles?

Who sponsors the program?

What is the administrative set-up?

What services are offered to the patients or clients?

What are the rules and policies of the institution?

What agencies work with the institution and which ones are visited on field trips?

How many case histories and book reports are to be written?

What date are they due?

What books are available for reference?

Where and how are they obtained?

Is there a staff education program and are students included?

Do students attend clinics and are they permitted to observe treatment in other departments.

What time is set aside for lectures, case reviews and discussion?

How, and how many patients or clients are assigned to each student?

Are supplies purchased or requisitioned? How are they obtained?

The above questions are fundamental to every training center. From experience it has been found that if they are not answered in the initial week the student has difficulty in adjusting. Facts dissolve fears and create a sense of knowing that results in truly comprehensive orientation.

A student may be defined as a person devoted to the acquisition of knowledge. As this signifies a lasting art in the process of living, and we are all students, questions should be welcomed—and answered, discussed or referred to authoritative sources. Intellectual curiosity is a good trait and if the clinical director cannot answer a question she, as well as the student, gains knowledge by research. It is never a crime not to know all the answers; it *is* a crime to be evasive and superior to cover a lack of knowledge. We must live to learn in order to learn to live. Occupational therapy will grow and expand through the ideas that germinate in the minds of the students. The wisdom gained from experience in the field should be given freely to those who sincerely seek it to permit growth without stunting. Mistakes grow in any soil very much like weeds, and if the clinical director will bear this in mind, an atmosphere that is conducive to better understanding and training will result.

In an experiment to find out if students gain more from field trips if given a tentative list of leading questions to ask, the following was discovered: the students sent on field trips with no previous preparation in leading questions did not gain as much from the visit as those sent with questions in mind; when two or more students were sent they gained more in proportion and also brought back livening material for discussion at student conference.

One of the most important attributes of a student is good patient contact and each clinical director is alert for this quality. The patient or client must be considered by the student as a whole, living, dynamic personality—not only as a mentally or physically handicapped person in need of treatment. The patient or client is an individual with a personality and when the student approaches an individual with this in mind she is better able to apply the theory and techniques of occupational therapy and thus treat the patient or client therapeutically. The whole person must be considered and a rapport must exist between the student and the individual to gain the desired results and eliminate apprehension.

To be objective is one of the most difficult lessons to learn—the Self is powerful and tends toward subjectivity. It is this subjectivity on the part of the clinical director, that the young enthusiastic student finds overpowering and difficult to understand. Experience has shown that constructive criticism is always welcomed by the recipient, and students are as a whole, grateful for correction which is given objectively with their welfare in mind. This opportunity to learn to evaluate through constructive criticism should be given to the student in the training center. This can be done in the form of a questionnaire, given to the student on the last day, with the stipulation that she return it at her convenience. The following questions can be asked:

What did you like most about your training at this center?

What did you dislike most about your training at this center?

Would you recommend this center as a good, fair or poor training affiliation? Give reasons.

The majority of students who are ready for affiliations are an asset to an occupational therapy program if given the proper guidance by the clinical director. When they are permitted to express themselves in an atmosphere that is unbiased and sincere in purpose, they respond with a zealous interest and energy that is most satisfying. Occupational therapy has a firm foundation and its growth and expansion is invested in the future therapists.

Some Thoughts on Occupational Therapy, the Work Shop and Rehabilitation

By COL. A. WILLIAM REGGIO, M.D.
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Somebody said a while ago that when an author incorporates in an article ideas, language or thoughts copied from some other writer, he is guilty of plagiarism. But if he does the same thing from a *number* of others—then—it is Research!

We do not want to be guilty of plagiarizing nor do we wish to give the impression that this bit of thinking is research.

What we do want to accomplish however is to bring into the open a few thoughts that we have been mulling over for some time and which—according to our way of thinking—should be given some serious consideration.

Persons in the field of physical medicine and its ancillary branches with whom these ideas have been discussed seem to agree to a larger extent. Undoubtedly there are still others who might disagree and even some who would not know what it is all about and care less.

But let us get to the point and see where it finally ends up.

The three terms that have caused all this are "Occupational Therapy," "Work Shop" and "Rehabilitation." Even now there are many people, including quite a number in the medical profession who still think of:

1. *"Occupational Therapy"* as just a lot of doodaddling in making various perfectly darling (?) *things* through the medium of arts and crafts.
2. *"Work Shop"* as being a tidy, clean, neat room where several ladies in uniform show patients how to make pot holders and do weaving on a loom.
3. *"Rehabilitation"* as curing some poor unfortunates of their periodic, lost weekends or donating a wheel chair to some neglected paraplegic.

Maybe we are guilty of being rude — or worse — but it is better to face the facts of erroneous concepts and then at least try to correct these false impressions.

1. *Occupational Therapy* is functional. It is administered by professional, trained therapists who may adapt certain media, also found in the category of arts and crafts, to the needs of the patient in order to attain the functional result desired by the physician prescribing the treatment. The occupational therapist is not particularly interested in what the patient does *with* the material but is vitally concerned with what this material will do *for* the patient.

There is also occasionally a misconception of the meaning of "functional." It is usually thought of as making some deranged anatomical part function again as near to normal as possible as in the case of a visible (sometimes called orthopedic) defect.

But the thinking has not gone far enough—what about the psychiatric aspects of functional therapy? There is seldom a *visible* anatomical defect but there is a defect or pathological upset just the same, only it is above rather than below the eyebrows. Restoration to normal function is the objective of therapy here just as much as in other visible, anatomical defects. Anatomical or mental restoration—it makes no difference—both are functional jobs.

Whether this form of therapy is termed diversional or recreational makes no difference so long as it is purposeful and functional and administered by a professional therapist.

Occupational therapy is *given* and *taken* on prescription in contra-distinction to the purely recreational or diversional type which is *offered* and participated in (or not) by the patient on a voluntary basis and *conducted* by non-professional (medically) arts and skills personnel. It is a very valuable and necessary service in a hospital and in no way do we minimize its importance but it should *not* be the duty of the professional, trained occupational therapist to be in charge of this activity. It belongs in the realm of the recreational worker.

2. The *"Work Shop"* is the place where functional therapy is administered when the patient is able to leave the ward and continue some-

what more vigorously the therapy prescribed and frequently commenced on the ward.

It seems to us that a broader concept of therapy must be adopted if we are to advance instead of remaining static in the functional activity of the work shop.

Why is a patient referred to the occupational therapy department? Presumably in order to have him regain function as quickly as possible. This means that his muscle power is to be regained; work tolerance steadily increased; coordination restored and the ability to resume his former occupation speeded.

Therefore, it would seem only reasonable that his therapy is planned along the lines of the work he already knows how to do and which he must do again. For example, a "rigger" must splice wire rope and use certain tools in the process. So why not start his therapy by having him splice rope (which he already knows how to do) rather than teach him how to make a pot holder? Splicing quarter-inch hemp or other soft rope will accomplish the functional purpose as readily as making a pot holder with the added advantage of familiarity with the process and consequently better co-operation on the part of the patient because he can see the rationale of his therapy at once.

In other words, the therapist, having made a job analysis of the patient's occupation, can and does adapt the patient's job to his therapeutic needs rather than having to make the patient adapt himself to an unfamiliar activity in which he sees no sense and may quite frequently feel somewhat resentful at what to him appears to be rather childish.

Similarly with adapting other therapy activities through which the muscles he has always used and must use again in his job are brought into play and restored to the patient's functional and economic needs.

Personally, we are in favor of banning all show cases from the vicinity (proximate or distant) of an occupational therapy department and in their place have informative and easily understood graphic presentation of a "before, during and after" nature. These can explain in simple, graphic form the why and wherefore of the therapy.

3. *Rehabilitation* is essentially the physical and/or mental restoration of an individual to the fullest economic usefulness of which he is capable. There is not an official definition but it presents in a short form what it means.

It is the prime objective of occupational therapy and for this reason merits considerable emphasis in the curriculum of our schools of occupational therapy.

Many factors are involved in the process of rehabilitation. In the June, 1947, issue of this Journal (Vol. 1, No. 3, page 149) we set down the 10 factors which we consider essential in the "Teamwork" necessary to the functioning of a sound program. We trust the reader of this article will forgive us for putting them down here again but it will save the effort of pulling the old Journal out of the file!

They are:

1. Mental Hygiene or Psychological Preparation
2. Social Service
3. Morale maintenance and building up
4. Physical Therapy
5. Occupational Therapy
6. Recreation and Entertainment
7. Education
8. Vocational Counsel
9. Physical and Vocational Rehabilitation
10. THE WILL TO GET WELL.

We had noticed for some time that but a few of the schools had the word "Rehabilitation" actually set down in their catalogues among the subjects taught in the curriculum. We have been informed, however, that the subject is taken up in the teaching at every school and the subject conscientiously covered.

Just the same it would be more reassuring to those interested if they could see "Rehabilitation" actually in print in the catalogues as it is so vitally important to the rounding out of a complete curriculum which we know is already very crowded.

It is earnestly hoped that the presentation of these thoughts (not plagiarism or research!) will be taken not as criticism but as an endeavor to help our thinking towards the fuller concept of occupational therapy and the basic didactic and clinical training of those who in the years to come will have the opportunity of putting their profession in its rightful place among the ancillary services to medicine.

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SCHOOL SECTION

UNIVERSITY OF KANSAS OCCUPATIONAL THERAPY CURRICULUM

Lawrence, Kansas

By NANCIE B. GREENMAN, O.T.R.
Asst. Professor and Advisor

Fowler Grove

The University of Kansas was provided for in the first constitution of Kansas territory in December, 1855. In 1861 Congress reserved for the use and support of a state university seventy two sections of land. In 1863, Lawrence, located in eastern Kansas forty miles from the Missouri line, was selected as the location of the university, and in 1864 the university was organized by the legislature. The Board of Regents held its first meeting on March 25, 1865, and on July 19, 1866, elected the first faculty, which consisted of three members. In the same year the first session of the University opened on September 12 with an enrollment of twenty-six women and twenty-nine men. From this beginning the enrollment has grown to 9500, the greater number now being Kansas residents. Because of these large and unprecedented numbers admission restrictions have been necessary, and very few out-of-state students are accepted; these must possess exceptional ability.

The occupational therapy curriculum was planned and organized in 1940 and 1941. The course was established in the School of Fine Arts under the direction of the Design Department and the Medical School and opened in the fall of 1942 with six students enrolled. By 1943 the curriculum was established, there

were thirty-four students enrolled, and the school was approved by the American Medical Association. Since that date the enrollment has increased to, and remains at, eighty-five students. There are now thirty-six alumnae, and the third official class graduates in June.

This curriculum was established for two major reasons. In the first place a great need was felt at the university for professional courses that women might enter. At that time occupational therapy was a little known profession in the middle west, and by establishing the occupational therapy curriculum, knowledge of the profession was expected to spread. Secondly, with the shadows of war appearing, the university foresaw the tremendous need for women trained in occupational therapy.

A student spends six semesters on the main campus at Lawrence, one semester on the medical school campus in Kansas City, and twelve months' clinical training in hospitals from Connecticut to the state of Washington. One hundred twenty-two credit hours are required for the degree, Bachelor of Science in Occupational Therapy, and the degree is not awarded until all clinical training has been completed. Also at the time, a Certificate in Occupational Therapy is granted by the Department of Physical Medicine of the University of Kansas Medical School. In the past a diploma course was offered to those persons already possessing a Bachelor's degree, but this has been discontinued since the enrollment did not justify its existence. Two classes are admitted each year, and from her first semester each student is wholly under the jurisdiction of the occupational therapy advisor.

During the freshman year the student enrolls in liberal arts subjects, crafts, and six hours of Biology and Physiology. These are continued in the sophomore year with six hours of Bacteriology and Zoology, and the addition of Psychology and two courses in Occupational Therapy Theory. In the junior year the student carries five hours of Anatomy and two hours of Kinesiology in classes with physical therapy students. Two more Occupational Therapy Theory courses are added at this time. The last academic semester is spent in the medical school where seventeen credit hours are carried in Medical and Surgical Diseases, Applied Physiology, Neurology, Psychiatry, Orthopedics, Pathology, X-ray, and Occupational Therapy General Hospital Theory, under the direction of the medical school staff.

Both beginning and advanced woodworking are taught in the university's machine and wood shops, and typesetting and job printing are carried on in the University Press Room. These classes are conducted by specialists in their fields, as are classes in ceramics, bookbinding, jewelry and silversmithing, and weaving. Photography is taught by the University Medical Center photographer. A course in music in therapy, given by one of the pioneers in the field, has just been added to the curriculum.

The introductory Occupational Therapy Theory course is concerned with history and orientation, ethics, tuberculosis, cardiac conditions, general hospital work, and pediatrics. The second course deals entirely with psychiatry. As an integral part of these courses, the student spends two hours per week pre-clinical training in geriatrics at a local convalescent hospital. Both of these courses are taken during the sophomore year. The third theory course covers neurological conditions such as poliomyelitis, cerebral palsy, peripheral nerve injuries, chorea and hemiplegias. The last course is concerned with arthritis, amputations, fractures and burns.

As previously stated, twelve months of clinical training are required of each student. These twelve months are broken down into four three-month training periods: psychiatry, tuberculosis, physical injuries and general hospital, and pediatrics including cerebral palsy. The university makes a conscious effort to try to emphasize equally all fields of occupational therapy feeling that a student has the right to see all fields impartially. Following the completion of four academic semesters, the more mature students are offered the opportunity of taking the psychiatric affiliation before beginning the junior year. No student does this without the necessary prerequisites. The administration believes that by following this pattern the last three academic semesters are more meaningful, and the student brings back to the campus a more mature point of view. An individual may, however, take all of her clinical work together at the end of her academic instruction. The university is currently

ACCREDITED SCHOOLS OF OCCUPATIONAL THERAPY

and those with Accreditation Pending †

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Division of Home Economics
Fort Collins, Colorado
Asst. Prof. Helen Tobiska, OTR
Director, Occupational Therapy

Columbia University
College of Physicians and Surgeons
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Miss Marjorie Fish, OTR, Director
Miss Marie Louise Franciscus, OTR
Acting Director of Training
Courses in Occupational Therapy

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College of Medicine, Dept. Physical Medicine
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using twenty-six hospital and workshop departments for clinical training.

This past fall, what promises to be a lengthy and worthwhile program of vocational testing was inaugurated through the cooperation of the university's Guidance Bureau. A series of tests concerned with general intelligence, natural and physical sciences, mathematics, English, personality, art judgment, manual dexterity, spatial relationships, and reading ability were chosen with the hope that scores on the tests would indicate an individual's physical and emotional fitness for occupational therapy. Should this field not seem to be indicated, some other interest or group of interests will usually be shown, to which the student may be directed. It will naturally be a matter of time before any validity in the testing program can be evident, but a most encouraging trend is already apparent.

Occupational therapy students are active in all phases of campus life, and the administration is concerned with the concept of turning out not only well trained therapists, but also emotionally well-adjusted persons, able to take their places in an ever-changing society.

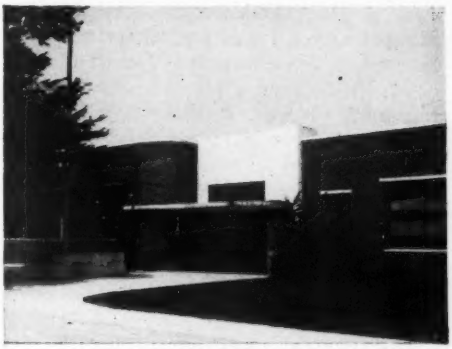
MICHIGAN STATE NORMAL COLLEGE SCHOOL OF OCCUPATIONAL THERAPY

Ypsilanti, Michigan

By GLADYS TMEY, O.T.R., B.S., M.Ed.
Supervising Director

The Michigan State Normal College (originally Michigan State Normal School) at Ypsilanti, Michigan, was created by an act of the Legislature in the spring of 1849, and in the fall of 1852, the first building having been completed, the school was opened. It was the first state normal school in Michigan, the first west of the Alleghenies, and the sixth in the United States. The College is approved or accredited by The American Association of Teachers Colleges, The North Central Association of Colleges and Secondary Schools, and The American Association of University Women.

Ypsilanti is thirty miles from Detroit in the heart of the industrial area of southeastern Michigan. The campus is six miles from the University of Michigan at Ann Arbor. This



Horace H. Rackham School of Special Education and Center for the School of Occupational Therapy

location offers many cultural and recreational opportunities to the students as well as the educational facilities of the Medical School and Hospital for the students in Occupational Therapy.

The College offers courses in preparation for all types of public school service. It gives preparation for supervisory and administrative positions and for the teaching of the various subjects offered in the high school and elementary school. It is also the school designated to give paramount instruction in Special Education which deals with certain types of handicapped children, and serves as the center for the University of Michigan for graduate study in this area. Graduate work at Michigan State Normal College is offered in cooperation with the University of Michigan, the graduate program being under the general supervision of the Horace H. Rackham School of Graduate Studies. Pre-professional courses in Business Administration, Law, Medicine, Dentistry, Engineering, Forestry, and Social Work are offered. In addition, the College offers a degree course in Occupational Therapy approved and accredited by the American Occupational Therapy Association and the Council on Medical Education and Hospitals of the American Medical Association.

All students enrolled at Michigan State Normal College live in the College Residence Halls unless they are domiciled in their own homes. The Julia Anne King Residence Hall, the Bertha Goodison Residence Hall, and the

Lydia I. Jones Residence Hall together have accommodations for all women students. These halls, which are conveniently located with reference to the library, provide students with a reasonably priced, attractively furnished, and well governed residence where they may enjoy the influence of a cultured home and a program of worthwhile activities. Furniture and arrangements are designed for the convenience of students. The suite arrangement of a study and bed-room provides excellent conditions for study and rest. Telephones serve all study rooms.

The College maintains a health center wherein service may be procured. Each Occupational therapy student is given a medical examination upon registration, and this is repeated annually until graduation.

Members of the incoming freshman classes are required to be present during the period known as Freshman Days. At this time, each freshman is given a great deal of individual attention and the best possible start in a college career. Talks on the curricula open to students and on various phases of college life are given by administrative officers and other members of the faculty. "Campus Sisters" and the "Fellowship Group of the Men's Union" acquaint students with college traditions and offer a program of social activities which prevent homesickness and establish those friendly relations which are characteristic of the College.

The School of Occupational Therapy is a division within the Department of Special Education and the facilities of the Horace H. Rackham School of Special Education, as well as of all other departments of the college, are available to the student. The curriculum consists of four years of college work, followed by ten and one-half months of hospital training and practice. Upon its completion, the graduate is eligible for a Bachelor of Science Degree, an Occupational Therapy Certificate, a Michigan Teacher's Provisional Certificate, if desired, and is qualified for entrance by examination to the Registry maintained by the American Occupational Therapy Association. Clinical courses and medical lectures are offered by the medical staffs of the Ypsilanti State Hospital and the University of Michigan Hospital, each of which is located within five miles of the Campus. College buses take the students to and from these classes. Before beginning the senior year, each student is assigned to work under the direction of a registered occupational therapist at an affiliated hospital for a minimum of four weeks of pre-clinical training. This experience affords the student an opportunity to observe occupational therapy and its relation to the other services within a hospital. It provides both the student and the College with a gauge of her adaptability to this type of work.

The School does not offer diploma or advanced-standing courses as such, but students entering with degrees or diplomas in other fields are credited with previous creditable work which applies to the curriculum, and a program is especially planned to fit the student's particular needs. All students must earn a Bachelors Degree in Occupational Therapy to receive a certificate in Occupational Therapy. One of the School's unique features is that of training its students chiefly within a close radius of the campus so that the director has easy access to the supervision and guidance of the students while in clinical training.

The School of Occupational Therapy of Michigan State Normal College dates from 1941, when, through the joint efforts of Professor Charles Elliott, Director of the School of Special Education at the College, Dr. George F. Inch, Superintendent of the Ypsilanti State Hospital and Miss Mary E. Black, O.T.R., Director of Occupational Therapy at the Ypsilanti State Hospital, the College opened its doors to the first students in Occupational Therapy. The program was planned as a joint effort of the Ypsilanti State Hospital, the University of Michigan Hospital, and the College. The medical staff of Ypsilanti State Hospital under Dr. P. N. Brown, Assistant Medical Superintendent, provides the clinical work in psychiatry and neurology. The University of Michigan Hospital staff under the direction of Dr. Henry K. Ransom, Associate Professor of Surgery, provides clinical lectures in pathology, medicine and surgery, orthopedics and pediatrics. The physical therapist at the Rackham School of Special Education gives the specialized work in applied kinesiology and orientation in physical therapy. Students take many of their classes in the Rackham School of Special

Education where they have the opportunity to work with and study children with various types of disabilities. They have the privilege of attending the clinics serving these children regularly, and of observing the physical therapist in her treatment of children with orthopedic disabilities. Professional workers in the fields of Rehabilitation and Social Service are invited to participate, through special lectures and field trips, in the orientation of the students in the various public and private agencies with which occupational therapists may be called upon to cooperate in a total rehabilitation program. About two years of the student's work is taken with the regular college students and two years in classes especially designed for the education of the students in Occupational Therapy.

The School of Occupational Therapy was approved and accredited by the Council on Medical Education and Hospitals of the American Medical Association in February, 1944. The first students to become registered occupational therapists completed their work in time for the first National Registration Examination which was offered by the national organization in June, 1945. To date, approximately fifty students have graduated and become Registered Occupational Therapists from this School. The School is not seeking numbers, but aims to turn out carefully selected and well-trained therapists.

FEATURED O. T. DEPARTMENTS

Occupational Therapy at the Indiana University Medical Center

MRS. WINIFRED C. KAHMANN, O.T.R.,
Director, Occupational and Physical Therapy

Occupational therapy was pioneered in Indiana by the Junior League of Indianapolis more than a quarter of a century ago when, anticipating erection of the James Whitcomb Riley Hospital for Children, the League started occupational therapy in the children's ward of the Robert W. Long hospital in 1922.

Scope of the Occupational Therapy program during the ensuing 26 years has kept pace with the expansion of the Indiana University Medical Center and today the service includes units in the Riley (children), Long (adults) hospitals and the Rotary Convalescent Home. In addition the service is also provided upon request to patients in the William H. Coleman hospital for women, also a part of the Medical Center.

The Indiana University Medical Center (1040-1232 West Michigan Street, Indianapolis) combines teaching with hospital service. On its 76-acre campus are the University's School of Medicine, School of Dentistry, Training School for Nurses, Courses in Medical Technology and Dietetics and Clinical training in Occupational and Physical Therapy for students meeting the standard professional qualifications.

The Occupational Therapy Department is organized with a director and four staff therapists, the staff members serving as supervisor of occupational therapy units in the general hospital, the convalescent home, the orthopedic ward, and the pediatric and surgical services of the children's hospital.

Students from 10 schools of Occupational Therapy are accepted for clinical training by the department. Six students at a time are provided living quarters, meals and laundry during a two or four month training period, depending upon the service to which the student is assigned.

Departmental offices and the central supply for all units are located on the second floor of the Riley hospital for children, just above the orthopedic ward and physical therapy department and on the same floor as the medical,

surgical and E.N.T. wards. Its convenient accessibility is an asset to the service, especially in the transportation of patients and close correlation with Physical Therapy. Most of the recreation and entertainment for the children, such as bi-weekly movies and special parties, are held here.

The occupational therapy program at Riley illustrates both the extent of this service at the Medical Center and its advantages in clinical training of students.

O.T. and P.T. Staff

The Riley hospital for children, a memorial to James Whitcomb Riley, beloved Hoosier poet, is regarded as the largest hospital exclusively for children, in this country. In reality it is a general hospital for children with a staff and facilities for the treatment of all types of disease and physical disability.

Occupational therapy in the pediatric service at Riley embraces all types of medical cases and the treatment problems—disability limitations and maladjustments—are a challenge to the therapist and student. The orthopedic ward of 50 beds and the surgical ward, which includes burn cases having plastic surgery, are excellent training units for the occupational therapy student.

The variety and extent of clinical material with the facilities of the medical and nursing schools and their special libraries, social service, psychological service with psychiatric guidance and the close correlation with the physical therapy program, combine in providing desirable opportunities for the affiliation of students seeking clinical training in occupational therapy.

A Cerebral Palsy Clinic is maintained in the Riley hospital by the Department of Public Welfare. The integrated training program includes Psychometry, Physical Therapy, Occupational Therapy and Speech Training. A member of the orthopedic staff, as medical director, supervises the rotating staff of orthopedic resident physicians that conduct the weekly out-patient clinic. A therapy supervisor, two occupational therapists, two physical therapists, a psychologist, and a speech worker carry out the program of intensive training. Provision is made in the Rotary Home for those patients which need to be kept in the hospital in order to get the training program started.

The Rotary Convalescent Home affords excellent experience for training with polio patients, both adults and children, from the acute through the convalescent stage. Other long-term cases such as osteomyelitis, arthritis and cardiac conditions are also treated here.

The Long Hospital is a general hospital for adults and handles the full range of cases found in a teaching center.

Rounds on the various wards with staff physicians are routine for the occupational therapy staff and students. Observation of surgical procedures, isolation technique, lectures, seminars, and all essential treatment procedures as selected by occupational therapy supervisors are made available to the students.

An effort is made to encourage the occupational therapy student to apply the science of her theory while learning the art of service to the patient. The physician rules the destiny of the patient and it is our duty to develop within the student a genuine urge for service to the patient, according to his direction. The individual interests of the student must conform to the fundamental needs of the patient.

Occupational Therapy is now on the threshold of extensive development in the field of physical medicine. There is need for specialization and research in occupational therapy, in the various areas of medical, mental, and physical disability. This need is a challenge which occupational therapists must be prepared to meet.

Occupational Therapy Volunteer Assistants Training Course in New York City

By Mrs. Edgar D. Oppenheimer, O.T.R.

Chairman of Placement, Occupational Therapy Volunteer Assistants Training Courses
681 Fifth Avenue, N. Y. C.

It was five months after Pearl Harbor that the first students, fifteen in number, were started in a volunteer training course sponsored by the New York State Occupational Therapy Association. Because the professional therapists were working in departments depleted by the call to war service, a small group of occupational therapists organized the training course to prepare volunteers for this particular field.

As the war continued, the role filled by the volunteers became more and more important. The satisfaction of working where their services were needed helped to spread interest in the courses. The following figures present a summary of the student training activities of the committee:

students	trained,	Spring	1942 — 15
"	"	Fall	1942 — 55
"	"	Spring	1943 — 57
"	"	Fall	1943 — 82
"	"	Spring	1944 — 80
"	"	Spring	1945 — 74
"	"	Fall	1945 — 57
"	"	Spring	1947 — 24
"	in training,	October	1947 — 34

A recent survey of the needs of the veterans' municipal and voluntary hospitals shows that at least 70 volunteers could be absorbed now by occupational therapy departments.

The original committee of professionals was augmented later by members representing the United Hospital Fund, the Red Cross, the New York City Visiting Committee, the New York Junior League, the Museum of Modern Art, and the schools of occupational therapy at Columbia University and New York University. These organizations helped by providing rooms for lectures and crafts, arranging publicity, and recruiting volunteers. They were of great assistance to the therapists on the committee.

At first only voluntary and municipal hospitals were served. Shortly thereafter the military hospitals requested trained volunteers. With these needs crystallized, our training course took a definite pattern, based on the syllabus prepared by the Occupational Therapy Volunteer Assistants Training Committee of the A.O.T.A.

The first unit of training consisted of indoctrination lectures by speakers who were leaders in their fields. The lectures, totaling 18 hours, included the history of occupational therapy, types of hospitals using occupational therapy, the place of the volunteer with particular emphasis on hospital ethics and etiquette, three lectures on design and one on recreation.

The second unit included craft training. Artists and craft teachers gave instruction in weaving, woodwork, leather projects, utiliza-

tion of felt and waste materials, needlework and stitchery, finger painting, ceramics, knotting, netting. and hooking. The craft schedule changed with the hospital needs. At first emphasis was placed on crafts for women and children. With the military picture becoming more important, crafts suitable for men were added. Forty-eight hours were allotted to craft instruction.

Our third unit of work consisted of 18 hours of compulsory hospital apprenticeship. The course ended with an examination and the graduation for those who passed. Arm-bands and certificates were presented at graduation teas, which were addressed by prominent speakers. Placement in one of the 33 hospitals that we served then followed. We tried to fit volunteers into the hospitals to which they as individuals were best suited.

There are problems in every field of endeavor, but the problem of the volunteer is a difficult one. In choosing our students during the war, we were obliged to take many young women whose patriotism prompted them to serve. We made it clear in preliminary interviews that the ideal volunteer would give of her time promptly, faithfully, and with humility. We approximated our ideal—sometimes.

We found that many factors, however, contributed to the picture. One was the professional-volunteer relationship. In other words, the tact and resourcefulness of the volunteer were not always what we expected. To a tired, overworked, and competent professional such a person in her department was an added thorn. We have met with the professionals and have helped to clear our thoughts, and we have planned with them how to get the best service from their volunteers.

One example was the professionals' criticism of the time required to answer the volunteers' questions on the hospital or on some particular craft. The professionals have cooperated, and many now send their volunteers on a short tour of the hospital facilities with which they need to be familiar. Then they have a brief question and answer period to clear up any important points. This may still be too time-consuming for some O.T.R.'s, so a list of favorite questions and answers is posted on the bulletin board. Questions on crafts were successfully handled by several hospitals which have so-called "refresher courses." These consisted of one or more sessions where the professionals met with their volunteers and explained the standard procedure on the crafts most frequently used in their departments. The results were gratifying.

There are still many problems that need to be solved but so long as hospital budgets remain inadequate, the volunteer should be a welcome addition. If she has the temperamental qualifications which make her sympathetic to sick people and has the faculty of using her hands well her training course should prove a satisfaction to her as well as to the O.T.R.

Since the end of the war more than the usual 50% of the volunteers have discontinued their work in occupational therapy but the New York Committee feels that the need in the hospitals in this area is so urgent that it will continue to assist those professionals who request help.

SCOUT TROOP AT U. S. MARINE HOSPITAL

Boy Scout Troop, No. 36, 8 patients with Hansen's Disease, has received a charter from the national organization. They are all being treated at the U. S. Marine Hospital (leprosarium) at Carville, Louisiana.

Although the Scouts at Carville will be prohibited from taking part in Scout activities "outside," there presumably will be no prohibition on other Scouts visiting the Carville troop.

O-TEASERS

1. What is meant by "localization of function" relative to active exercise in orthopedic Occupational Therapy?
2. Name ten diagnoses of the neurological group.
3. What is the unwritten prescription for the therapist?
4. What are the four basic steps in good instruction to patients?
5. When did O.T. registration go into effect?
6. When were schools of O.T. approved by the American Medical Association?
7. What is the oldest of all known diseases?
8. Does athetosis chiefly concern joint movement or specific muscle involvement?

See page 189 for answers.

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Legislative and Civil Service Committee
H. Elizabeth Messick, O.T.R., Chairman
Permanent Convention Committee
Lucie Spence Murphy, O.T.R., Chairman
Public Relations Committee
To be appointed
Subcommittee on Finance
Mrs. Guy Misson, Chairman
Subcommittee on American Journal of O.T.
Charlotte D. Bone, O.T.R., Chairman
Subcommittee on Exhibits
Ella Fay, O.T.R., Chairman
Registration Committee
Eva M. Otto, O.T.R., Chairman
Hyman Brandt, Ph.D., Consultant

SPECIAL COMMITTEES

Poliomyelitis Research Committee, Sue P. Hurt, O.T.R.
Rules, Procedures Committee, Sister Jeanne Marie, O.T.R.
Volunteer Assistants Training Course, Carolyn Oppenheimer, O.T.R.

HOUSE OF DELEGATES

Speaker of the House ..... Harriet J. Tiebel, O.T.R.
Vice Speaker ..... Dorothy Flint, O.T.R.
Secretary ..... Edna-Ellen Bell, O.T.R.
California, Northern ..... Mary Booth, O.T.R.
California, Southern ..... Carlotta Welles, O.T.R.
Colorado ..... Josephine Davis, O.T.R.
Connecticut ..... Bertha J. Piper, O.T.R.
District of Columbia ..... Violet H. Corliss, O.T.R.
Hawaii ..... Esther Pyun, O.T.R.
Illinois ..... Isabel M. Kellogg, O.T.R.
Indiana ..... Edna Faeser, O.T.R.
Iowa ..... Marguerite McDonald, O.T.R.
Kansas ..... Myrl Anderson, O.T.R.
Kentucky ..... Nell McCulloch, O.T.R.
Maryland ..... Mrs. E. Stisser Owen, O.T.R.
Massachusetts ..... Jane Merrill, O.T.R.
Michigan ..... Marion R. Spear, O.T.R.
Minnesota ..... Borghild Hansen, O.T.R.
Missouri ..... Dorothy Flint, O.T.R.
New England, Northern ..... Doris Wilkins, O.T.R.
New Jersey ..... Naida Ackley, O.T.R.
New York ..... Harriet J. Tiebel, O.T.R.
New York, Western ..... Cornelia Smith, O.T.R.
Ohio ..... Minnie Fevold, O.T.R.
Oregon ..... Marjorie Englehardt, O.T.R.
Pennsylvania ..... Ruth Greve, O.T.R.
Pennsylvania, Western ..... Bessie Clark, O.T.R.
Texas ..... Lenore Brannon, O.T.R.
Virginia ..... Mary Junkin, O.T.R.
Washington ..... Edna-Ellen Bell, O.T.R.
Wisconsin ..... Ruth Bell, O.T.R.

1948 CONVENTION

Sept. 4-6 Pre-Convention Meetings
Sept. 7-9 Convention
Sept. 10-11 Institute, Field Trips

SPECIAL MEETINGS

Saturday, September 4

Morning
10:00- 2:00 Advance Registration
9:00- 1:00 Education Committee, joint meeting

Afternoon
2:00- 6:00 Subcommittee on Schools and Curriculum
Subcommittee on Clinical Training

Evening
8:00-10:00 Clinical Research and Service Committee
7:30-10:00 Registration Committee

Sunday, September 5

Morning
10:00- 1:00 Subcommittee on Schools and Curriculum
Subcommittee on Clinical Training
Special Committee on Poliomyelitis

Afternoon
2:00- 5:00 House of Delegates
Subcommittee on Schools and Curriculum
Subcommittee on Clinical Training

Evening
7:00-10:00 House of Delegates
Education Committee

Monday, September 6

Morning
9:00- 1:00 Board of Management
9:00- 5:00 Setting up Educational Exhibit

Afternoon
2:00- 4:00 Board of Management
4:00- 6:00 Tea for AOTA officers, House, Committees

Evening
7:30-10:00 House of Delegates
Permanent Convention Committee
Committee on Rules and Procedures

Thursday, September 9

Afternoon

1:30- 5:00 Board of Management

Evening

7:00-10:00 Board of Management

NOTE: *Final convention program in next issue*

LOCAL CONVENTION COMMITTEE

General Chairman
Miss Susan C. Wilson, O.T.R.
681 Clarkson Ave.
Brooklyn 3, N. Y.

Banquet
Mrs. Edgar D. Oppenheimer, O.T.R.
1148 Fifth Ave.
New York 28, N. Y.

Demonstration and Exhibits
Mr. Martin W. Neary, O.T.R.
Rockland State Hospital
Orangeburg, N. Y.

Extra-Curricular Activities
Mrs. Harriet Jones Tiebel, O.T.R.
10 Hard St.
Floral Park, N. Y.

Hospitality
Miss Mildred A. Spargo, O.T.R.
Payne Whitney Clinic
New York, N. Y.

Institute
Miss Elizabeth H. Smedes, O.T.R.
Box 695
Stonybrook, L. I., N. Y.

Printing
Miss Julia C. Olivo, O.T.R.
Sea View Hospital
Staten Island, N. Y.

Program
Miss Frieda J. Behlen, O.T.R.
N.Y.U. School of Education
Washington Square, New York 3, N. Y.

Publicity
To be appointed

Registration
Mrs. Blanche Maisel Ringel, O.T.R.
58 West 83rd St.
New York 24, N. Y.

Round Tables
Miss Marguerite Abbott, O.T.R.
Occupational Therapy Dept.
College of Physicians and Surgeons
Columbia University, 630 West 168th St.
New York 32, N. Y.

Transportation
Mrs. Evelyn Joseph, O.T.R.
931 Fox St.
Bronx 59, N. Y.

DR. HOWARD RUSK TO SPEAK AT BANQUET, SEPT. 8, 1948

Dr. Howard A. Rusk's name is well known to Occupational Therapists, but the range of his achievements and present activities is so unusual, it is thought a resumé of his career will be of interest to our readers.

Dr. Howard A. Rusk

First, as Dr. Rusk, he practiced internal medicine in St. Louis, Mo., where he was also an instructor at Washington University and Associate Chief of Staff at St. Luke's Hospital.

Then, as Col. Rusk, he set up the Air Forces Convalescent Services, which became the model used by both Army and Navy Medical Corps, and the Veterans' Administration in organizing their own rehabilitation programs. For this job, Col. Rusk was awarded the Distinguished Service Medal in 1945.

After V-J Day, as a civilian once more, Dr. Rusk decided that something should be done toward applying the rehabilitation methods instituted by him in military hospitals, to the disabilities of civilians injured in accidents or catastrophes of various sorts. Numerically, this group is much bigger than all the American war casualties put together.

To facilitate his aim of bringing modern rehabilitation to the housewife, the school child, the industrial worker, and even to the careless or unlucky motorist, Dr. Rusk has assumed a many-sided career of publicist, teacher, organizer and executive. At present he is Associate Editor (Rehabilitation), of the *New York Times;* Consultant in Medical Rehabilitation to the Administrator, Veterans' Administration, and to the Secretariat, United Nations; Professor and Chairman, Department of Rehabilitation and Physical Medicine, New York University College of Medicine.

Dr. Rusk will speak on "Rehabilitation: A Challenge to Occupational Therapy."

WE WANT YOU!!

or

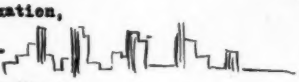
NEW YORK HAS EVERYTHING!

Our wish is to bring this to your attention ------

September 7 - 11 are the days of the A.O.T.A. Convention.

And too, should you be seeking relaxation,

New York's the spot for recreation -



So sit down now and make your reservations.

For those of cultural and international inclination,

We offer arts and crafts, museums, O.T. projects and the United Nations.

Fifth Avenue offers the latest in styles -

If you don't mind walking miles and miles!

Or if you'd like to view New York skyline and be nautically merry,

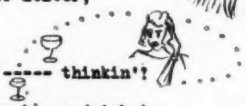
You can ride back and forth on the Staten Island Ferry.

If a panorama you long to contemplate,

There's nothing to equal the top of the Empire State.

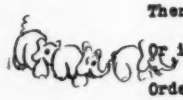
Or if you're in the mood to dance or loiter,

Pay a visit to the Latin Quoiter.



Do you want to do a little serious ----- thinkin'?

Then there are millions of places to buy a drink in.



Or if you fear gettin' a jag- on,

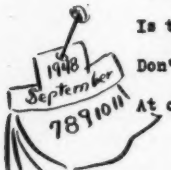
Order Coca-Cola, Pepsi-Cola, malted milk or orange juice and stay on the wag-on.

By now you see that New York is a swell place to visit -

You'll really be silly if you are to miss it.

So take to heart this sales talk, for our Committee's ideer

Is to make all O.T.'s wanna conventioneer.



Don't vacillate or procrastinate; come on YOU - ALL, let's congregate,

At our All -Out meeting in '48 !!!!!!!

By patients Robert Middleton and Murray Lewis, Marine Hospital, Neponsit, Long Island, N.Y.
with contributions by the Transportation Committee.

PEOPLE YOU WILL MEET AT THE 1948 CONVENTION

Dr. Woodward *Dr. Storms*

Dr. Harold D. Storms, Director of Physical Medicine, Convalescent Centre, The Workmen's Compensation Board, Malton, Ontario, was educated at the University of Toronto. During World War I he served in the British Army, and in 1917-1918 was Medical Officer in Command, Hamilton Military Hospital. He was Vocational Medical Officer, Dept. of Soldiers' Civil Rehabilitation 1918-1919, and after that, engaged for many years in private practice.

In 1932 he founded, and became Medical Director of Rehabilitation of the Workmen's Compensation Board of Ontario. In World War II he served as Chief Instructor of Physical Medicine for the Canadian Army in Canada, and was retired with the rank of Lt. Colonel, Royal Canadian Army Medical Corps after a total service of 36 years in the Canadian and British Armies.

His paper, "Techniques in the Rehabilitation of the Orthopedically Handicapped" is scheduled for Wednesday afternoon, September 8, 1948.

* * * * *

Luther Ellis Woodward, MA, Ph.D, FAOA, Co-author with Thomas A. C. Rennie of *Jobs and the Man,* 1945, and *Mental Health in Modern Society,* 1948. Co-author with Dr. John E. Crawford of *Better Ways of Growing Up,* 1948. Contributor to professional journals in Mental Hygiene, Social Work and educational fields.

Dr. Woodward has had a distinguished career in Child Guidance, where he not only did psychiatric social work with children and adolescents, but also assisted with in-service training of teachers, guidance counselors and other personnel.

In 1943 Dr. Woodward was Field Director, Liaison with Selective Service, where he was instrumental in improving the selection of men for the Armed Forces through study of school, work, health and social productivity records in the pre-induction histories of selectees.

At present he is with the National Committee for Mental Hygiene as Field Consultant, Division of Rehabilitation. This work involves nation-wide planning for rehabilitation services to patients, and in-service training of professional and industrial supervisory groups, together with public education and coordination of community resources.

Dr. Woodward will speak on efforts now under way, to facilitate the transition of the convalescent mental case into the Federal Vocational Rehabilitation Program. His paper, "Techniques in Vocational Rehabilitation of the Mentally Ill," will be given at the Wednesday morning session, September 8.

* * * * *

S. R. Slavson, Director of Group Therapy for The Jewish Board of Guardians, will deliver a paper, "Opportunities for Group Psychotherapy in Occupational Therapy" on the afternoon of Sept. 7th. Mr. Slavson, formerly on the faculty of the School of Education, New York University, and of Springfield College, is widely known as one of the pioneers in the therapeutic application of permissive techniques to group work. He is past president of the American Group Therapy Association, and former editor of the publication, "The Group." He has written extensively on his subject, and has contributed to many educational and psychological journals and symposia on psychotherapy. He is author of "Creative Group Education," "Character Education in a Democracy," "Science in the New Education," "An Introduction to Group Therapy," "Recreation and the Total Personality," and is editor and co-author of "The Practice of Group Therapy."

Mr. Slavson is also consultant in Group Therapy to the Community Service Society, The Bridgeport (Conn.) Mental Hygiene Society, The Newark (N. J.) Child Guidance Bureau and The Council of Child Development, New York City.

RESERVATION FOR HOTEL ROOM

Send to Mr. James R. McCabe, Manager, Hotel Pennsylvania, New York 1, N. Y.

Dear Mr. McCabe:—Please reserve accommodations as checked (√) below:

Name .....
(Please print)

Address .....

City ..... Zone ..... State .....

Unless requested otherwise, the hotel will hold reservation until 9 p.m. of the day of your arrival.

Date Arriving..... Hour..... a.m. p.m.

Room and Bath			6.00 ☐
for One	4.00 ☐	5.00 ☐	6.50 ☐
Per Day	4.50 ☐	5.50 ☐	7.00 ☐
Double-Bed Room			8.00 ☐
with Bath	6.00 ☐	7.00 ☐	8.50 ☐
For Two — Per Day	6.50 ☐	7.50 ☐	9.00 ☐
Twin-Bed Room			10.00 ☐
with Bath	7.00 ☐	8.50 ☐	11.00 ☐
For Two — Per Day	8.00 ☐	9.00 ☐	12.00 ☐
SUITE			14.50 ☐
Living Room, Bed Room and Bath		13.50 ☐	16.50 ☐

MORE THAN TWO PERSONS IN ONE ROOM

For each additional person in Double or Twin-Bed Room the extra charge is $2.00 per day.

If a room at the rate requested is unavailable, reservation will be made at the next rate.

1948 Convention of the American Occupational Therapy Association

RESERVATION FOR GUIDED TOUR TO U.N.

To be sent to Mrs. Evelyn Joseph, O.T.R., Transportation Chairman, c/o S. Haines, 931 Fox Street, Bronx 59, New York

RESERVATION FOR GUIDED TOUR TO U.N., Lake Success, N. Y., via chartered bus. Thursday, September 9. Leave hotel 1:15—return hotel 6:00. $2.75 Inclusive.

Name .....

Mailing Address .....

City ..... Zone..... State.....

If desired, check or money order may accompany this coupon.

It is not an exaggeration to say that no adequate history of the development of Group Therapy concepts or techniques could be written without reference to the works of S. R. Slavson. They are to be found on the "must" reading lists of physicians, teachers, social service workers, physical and occupational therapists, to name but a few groups whose interests are of a strongly sociological nature.

* * * * *

Mrs. Pratt *Miss Scullin*

Virginia Scullin, O.T.R., Director of Occupational Therapy, New York State Department of Mental Hygiene, Albany 1, N. Y.

Virginia's career in occupational therapy started as "Aide" (the term was still current in 1921) at Philadelphia General Hospital — the old Blockly before it got its face lifted.

In 1924 Mrs. Eleanor Clarke Slagle, then recruiting personnel for the New York State Hospital Rehabilitation Program, secured Virginia as Chief Occupational Therapist at Central Islip State Hospital on Long Island. Integrated Physical Training, Habit Training for regressed patients, Nurse orientation courses in occupational therapy, a Patient's Library, a printing press and a hospital publication were among the projects developed during her 9 years at Central Islip.

When Pilgrim State Hospital, the largest hospital in the world, was opened, Virginia was among those on hand. To pioneer occupational therapy in the largest hospital in the world might have daunted some, but not Virginia, who has the true pioneer gift of seizing and exploiting opportunity, and who can make bleak, stark places seem cozy and attractive by some magic peculiar to herself. Thus, at Pilgrim, she set up the same sort of program that had been so successful at Central Islip, though now it was less easy because funds had become tighter in the depression years.

Virginia Scullin has served the American Occupational Therapy Association as faithfully as she has the state of New York, having been a member of several important committees, and of the AOTA Board of Managers.

In 1946 she was appointed to her present position, succeeding the late Mrs. Slagle, founder and elder statesman of occupational therapy as the 20th Century understands it. This appointment necessitated a move to Albany, where Miss Scullin now lives. She is anxious to recruit for the New York State Department of Mental Hygiene a group of workers trained in the most approved methods of occupational therapy, and possessing characteristics like her own: appreciation of beauty, but also of human values; enthusiasm combined with excellent critical powers; the gift of leadership accompanied by staunch loyalty to both subordinates and superiors in the departmental hierarchy.

* * * * *

Mrs. Theresa E. Pratt began her career in Occupational Therapy at Brooklyn State Hospital in 1926. After three very successful years there she came to the Buffalo State Hospital. Here, in addition to her hospital assignment, she has taken advantage of various courses offered by the University of Buffalo and also has studied at several art schools in the city. In 1931 she became a registered therapist, and in October, 1933, she was appointed Chief Occupational Therapist at Buffalo State Hospital which position she still holds. Her excellent qualities of organizing and her unusual executive ability have helped her build up an O.T. department at Buffalo State of which she may be justly proud.

The Western New York Occupational Therapy Association owes much to Mrs. Pratt. She, with Miss Florence Northrup and Mrs. Dorothy Pollock Dilier, was a pioneer in organizing the Western New York branch of the N.Y.O.T.A. in March, 1935. She has been one of our most enthusiastic members since that time.

For the first ten years she served as an officer in the association. On the occasion of its tenth anniversary she wrote and prepared the brochure marking that period. In 1937

RESERVATION for INSTITUTE

To be sent to Miss Elizabeth Smedes, O.T.R., Institute Chairman
Address: Box 695, Stonybrook, L. I., N. Y.

Please find enclosed check for $7.50. Please insure my place at the Institute on Neuropsychiatric Conditions following the AOTA Convention, Sept. 10 & a.m. of Sept. 11.

Name .....

Mailing Address .....

City ..... Zone ..... State .....

The Institute fee is separate from hotel expenses. If you prefer to pay this fee at the time of registration, but expect now to attend the Institute, send the above coupon to Miss Smedes after crossing out the first sentence.

COUPON for the CONVENTION COMMITTEE

To be sent as soon as possible to Miss Susan Colston Wilson, O.T.R.
Local Convention Chairman, 681 Clarkson Ave., Brooklyn 3, N. Y.

I will attend the AOTA Convention at HOTEL PENNSYLVANIA, New York, arriving

on .....

I (will) (will not) attend the Institute on Neuropsychiatric Conditions.

(Institute all day Sept. 10; a.m. only Sept. 11, 1948)

Signature .....

Mailing Address .....

City ..... Zone ..... State .....

This coupon is to help the Convention Committee, and does not take the place of the Hotel Reservation Form nor Institute Reservation Form (above). Hotel Reservations should be made with the Hotel Pennsylvania, New York 1, N. Y., direct.

Registration fee for the Convention $4.00 to Members; no fee to non-members. Registration fees are payable Sept. 7, 1948.

she was elected to serve as first delegate to the House of Delegates, A.O.T.A. She has served on the Board for various terms and is now alternate delegate.

CONVENTION HIGHLIGHTS

The Museum of Modern Art extends an invitation to all members of the American Occupational Therapy Association to visit the Museum galleries and sculpture garden on Tuesday, September 7th, between 5:00 and 7:00 p.m.

The Museum's Department of Art Education is arranging for the occasion an exhibition of particular interest to Occupational Therapists, consisting of work done at the Veterans' Art Center. Refreshments will be served in the Sculpture Garden. (Arranged by the O.T. Volunteer Assistants' Training Courses.)

* * * * *

AOTA members will be granted the courtesy of admission, as spectators, to all meetings of the House of Delegates.

DELEGATES DIVISION

Dorothy L. Flint, O.T.R., Editor

DISTRICT OF COLUMBIA

Violet H. Corliss, O.T.R., Delegate-Reporter

Seven meetings have been held by the D.C.O.T.A. during the past year.

New officers were elected in May and reports given by outgoing officers and the various committees. It was decided at this time to hold no meetings during the summer months, it being difficult to get good attendance and extramural work done because of the hot, humid weather we have here so many months of the year. It was thought that officers and committees could do a better job in their new capacities if they started in the fall and continued without interruption until the next annual meeting.

The second meeting was therefore held in October and consisted in the main of a discussion of the agenda of the 1947 convention, the members discussing the various issues pro and con and giving the delegate voting instructions.

The principal business of the November meeting was the report of the delegate and other members who had attended the convention in California.

In January Dr. Douglas Noble, an instructor at the Washington School of Psychiatry and in private practice in Washington, addressed the association on new ideas in psychiatry, giving us good advice on the role of the occupational therapist in psychosomatic medicine and psychiatry. At the meeting Miss Laura Field, RPT, a fellow in the D.C.O.T.A., announced a course of lectures planned for next fall in the D.C.P.T.A. These lectures are to be given by a psychiatrist, an anatomist and a physiatrist.

Our next meeting, in February, was held jointly with the PTA at the Kabat-Kaiser Institute. Dr. Kabat explained to the combined group his theories on muscle re-education, resistive exercises and prostigmine in the treatment of neurological conditions and demonstrated physical therapy with several of his patients and explained that occupational therapy was used to teach the patient how to help himself in daily living.

Children's House, opened last fall, was the scene of our March meeting. This is a play center for children who have been unable to fit into any school and therefore have learning difficulties and those who have not learned to become part of a group and do not have socially acceptable behavior. Mrs. Susan Richards, O.T.R., is the director and all therapy is under psychiatric supervision. After a tour of this interesting set-up plans were discussed for a Tri-State meeting.

Walter Reed General Hospital played host to the Virginia, Maryland and District of Columbia associations in April. Miss Ruth Brunyate, O.T.R., Director of O.T., Children's Rehabilitation Institute, Cockeysville, Md., talked on "Cerebral Palsy" and showed a moving picture on the treatment of patients. "Occupational Therapy Treatment for Arm Amputees" was the subject presented by Lt. Ellen M. Lund, O.T.R., at Walter Reed. Many of the therapists had the opportunity of seeing for the first time an exposition of the various protheses. We also had the privilege of hearing Miss Wilma West, Executive Director of the A.O.T.A., give a talk, "Inside Your National Headquarters." We had lunch at the officers' club which gave members of all three associa-

tions the opportunity of getting acquainted with each other. After a tour of the Occupational Therapy shops, Dr. Valentine Ujhele, a psychiatrist on the staff of Walter Reed, told us of his use of Phantasiophoresis or Artificially Induced Dreams in therapy. Miss Margaret Gleave, O.T.R., Executive Director of the Delaware Curative Workshop, told of the history, development and operation of her rapidly expanding program. A wealth of adapted equipment used in occupational therapy with quadriplegics along the line of self-help was exhibited and explained by Miss Margaret Clarke, O.T.R., of the Richmond Veterans Hospital. All agreed that this was a most stimulating and educational meeting.

Among national affairs in the past year was the Women's Bureau Conference at the Labor Bureau, Washington, February 17-19. Several local members attended this conference which centered its speeches and discussions on the subject "The American Woman and Her Changing Role."

Several departments in Washington, thru the D.C.O.T.A., have contributed pictures, portraying various phases of occupational therapy, for the American Medical Association Convention which was held in Chicago, June 21-25.

The D.C.O.T.A. offered its services to the American Psychiatric Association whose convention took place in this city May 16-20. We received a negative reply as to services, but also an invitation to attend their meetings at a $3.00 registration fee.

The local association has been requested to contact The American Congress of Physical Medicine to obtain representation for the A.O.T.A. at its annual meeting to be held in Washington September 7-11. We have information on the space and will prepare an exhibit.

We have O.T. representation in The Washington Council For The Handicapped in which interest has been displayed for the development of a curative workshop. So far, however, there has been no planning.

OFFICERS

President: Miss Violet H. Corliss, O.T.R., Upshur Street Hospital, Washington 11, D. C.

Vice President: Miss Mary E. Nipher, O.T.R., Walter Reed General Hospital, Washington, D. C.

Secretary: Miss Austina Mallory, O.T.R., Mt. Alto Veterans Hospital, Washington, D. C.

Treasurer: Miss Grace Greenlie, O.T.R., Naval Hospital, National Naval Medical Center, Bethesda, Md.

VIRGINIA

Delegate Reporter — Ethel V. Teal, O.T.R.

Since last reporting the activities of our group, the Virginia Occupational Therapy Association has held six meetings of varied nature ranging from a journey through ice and snow of mid-winter to hear a discussion of art analysis in historic Williamsburg to a business meeting over broiled steaks in mid-summer!

The first of these meetings was held on February 22, of last year, at the Eastern State Hospital, the oldest mental institute in the United States, located at Williamsburg, Virginia. Florence Clemens, Director of the Occupational Therapy there, was hostess for the group which was made up of the hardy souls who braved one of the south's worst blizzards to attend. The subject for the meeting was a discussion of creative art as a diagnostic aid and its use in occupational therapy for the mental patient.

Hanover Recreational Park, north of Richmond, was the scene of an enjoyable summer meeting in picnic form. Plans were formulated for the fall meeting and for the publication of our first newsletter, "Old Dominion Data," which made its debut in late September.

On October 24 the Veterans' Administration Hospital in Richmond played host to the Va. O.T.'s. A buffet supper followed an afternoon program during which all phases of physical medicine as practiced here were described by members of the staff. The visiting group toured the various sections of the physical medicine department including the occupational therapy shops on the cord-injury, neuropsychiatric, tuberculosis and general medical and surgical services.

None of our members were able to attend the California convention but we were lucky to have Jane Myers, chief of occupational therapy for the Veterans' Administration, give us a good behind-the-scene description of the major events. She was guest speaker at a dinner-meeting January 9 at the Oak Leaf Inn in Richmond.

V.O.T.A. participated in the Tri-State Occupational Therapy conference held at Walter Reed General Hospital in Washington, D. C.,

Saturday, April 10. The District of Columbia O.T. Association was host to the Virginia and Maryland groups at a fine all-day meeting. Guest speakers included: Ruth Grunyate, Lt. Ellen Lund, Wilma West, Dr. Valentine Ujhele, Margaret Gleave and Margaret Clarke. The Virginia O.T.'s certainly hope the Tri-State meeting can become an annual event and continue the fine program level established at this meeting.

At our meeting in Richmond on April 30, there was an election of officers for the next year. We're looking forward to the continued growth and development of the V.O.T.A. and feel that the "growing pains" of the first five years have given us a basis for a fine future outlook.

OFFICERS

President: Walter J. Lee, O.T.R.
Executive Vice President: Miss Kathleen Kessler, O.T.R.
Recording Secretary: Mrs. Don Warburton, O.T.R.
Corresponding Secretary: Miss Margaret D. Clarke, O.T.R.
Treasurer: Miss Ethel V. Teal, O.T.R.

The House of Delegates
American Occupational Therapy Association

—FORMATION and FUNCTION—

The House of Delegates of the American Occupational Therapy Association is composed of one delegate from each of the affiliated state or regional associations.

Procedure for Affiliation of State or Regional Associations:

An Association, to be affiliated with the A.O.T.A., must meet the following requirements:

1. A minimum number of ten active members shall be required. The association must be composed wholly or in part of practicing registered therapists. Other members of the association should be placed in the same membership classifications as in the constitution of the A.O.T.A. Active members must also be active members of the A.O.T.A. (See A.O.T.A. Constitution.) In some of the older associations non-registered O.T.'s hold active membership. This is also true of the A.O.T.A. itself. All new members of associations, however, must meet the present membership standards. All associations requesting affiliation should conform with this policy. Associate or non-professional members may not vote.
2. An association requesting affiliation should submit a written request to the Secretary of the House of Delegates. A copy of its constitution and a list of all members showing their membership classification should also be sent.
3. The constitution should provide for the election of a delegate and an alternate, who shall be registered occupational therapists and active members of the A.O.T.A. for more than one year before the date of their election. The term of the delegate shall be three years, and he may serve only two consecutive terms; the term of the alternate may be three years or less.

Function of the House of Delegates:

The function of the House of Delegates is to make recommendations to the Board of Management of the A.O.T.A. regarding actions and procedures which it feels should be carried out. The House was formed in 1938 because it was felt that in this way it would be possible for local associations to present their problems and needs to the Board of Management. Likewise, through the Delegates the problems and needs of the A.O.T.A. could be carried back to the local associations.

Only in regard to changes in the national constitution does the House act other than a recommending body. All changes in the constitution must be approved by the House of Delegates, as well as the Board, before presentation at the annual meeting to the membership for vote.

The House is, however, represented on the Board by six of its members. It is also represented on the Executive Committee by one of its six Board members.

Officers of the House of Delegates:

ORGANIZATION OFFICERS

The officers of the House of Delegates are the Speaker, Vice-Speaker and Secretary. The Secretary also serves as Chairman of the Committee on Credentials. The officers of the House shall have served as delegates one year before being eligible. The term of these officers is one year, but they may be re-elected.

BOARD MEMBERS

Six members of the House are elected by the House to serve on the Board; their term being two years, three are elected each year to replace the three retiring. It has always been customary to elect these from the delegates who have served one year in the House. They

cannot be elected from those who are in their third year because such persons cannot complete their term as Board members. It is preferable to have the Speaker of the House one of the Board members, but this is neither essential nor always possible.

If for any reason a Delegate Board member is unable to complete his term, the Speaker may appoint another Delegate to fill his place until the next meeting of the House.

One of the six Board members serves on the Executive Committee. This is usually the Speaker of the House if it is geographically possible, and if the Speaker is a member of the Board.

The officers and Board members are elected at the close of the annual meeting of the House and serve through the next annual meeting.

COMMITTEES OF THE HOUSE

Appointment and Function:

THE COMMITTEE ON CREDENTIALS is the only standing committee of the House. Its chairman is the Secretary; its members are chosen by the chairman. Its duties are: (1) to pass on the credentials of all delegates and alternates at the annual meeting, (2) to consider requests for affiliation and recommend action to the Board, (3) to review the status of affiliated associations when so indicated.

THE NOMINATING COMMITTEE of three or more members is appointed each year at the first meeting of the House from those delegates not eligible for office. It chooses a slate of officers and Board members which is presented at the second meeting of the House.

Other committees are appointed as indicated. The Chairmen report to the Speaker twice yearly on their accomplishments.

Duties:

SPEAKER OF THE HOUSE

1. To preside at all meetings of the House.
2. To keep the delegates informed throughout the year regarding changes in policy or special actions by the Board, and to keep the Board informed as to feelings of the membership.
3. To prepare agenda for the meeting of the House, to be sent to the delegates in the spring for suggestions and additions.
4. To send out the final agenda to the delegates before the annual meeting.
5. To summarize the minutes of the meetings of the House for the record.
6. To request a stenotypist to record the minutes of the annual meeting of the House.

VICE-SPEAKER

1. To preside at the meetings of the House in the absence of the Speaker.
2. If the Speaker should resign, to complete the Speaker's term.
3. To serve as editor of the delegates' section in AJOT.

SECRETARY

1. To act as chairman of the Committee on Credentials.
2. To take minutes of the House meetings if a stenotypist is not available.
3. To send out credential forms, etc., to the delegates. (Actually this is done through the National Office, as is the clerical work on minutes, agenda, etc.)

DELEGATE BOARD MEMBER ON THE EXECUTIVE COMMITTEE

The Delegate Board member on the Executive Committee represents the House of Delegates and, regardless of his own opinion, should vote as directed on all subjects voted on or recommended by the House. On other matters the delegate uses his own judgment.

After each Executive Committee Meeting a report of actions taken, and the reasons for the actions, should be sent the delegates. The minutes of the Executive Committee Meeting may be sent as well as a more extensive report. The latter is preferred by the delegates, as the minutes give only the action taken, not the discussion and reasons for the action.

The Executive Committee meets every two to four months. It is empowered to carry out the aims and instructions of the Board of Management. It implements their decisions and acts as a finance committee for the Treasurer. It cannot initiate action on its own part but can make emergency decisions, subject to the approval of the Board. It also acts in an advisory capacity to the Executive Director and Educational Field Secretary.

DELEGATE MEMBERS OF THE BOARD OF MANAGEMENT

The delegate members of the Board represent the House of Delegates and must vote, regardless of their personal opinions, as instructed by the House on all recommendations of the House. On all other matters they are free to use their own judgment.

As a general rule, the Speaker's reports to the Board convey the recommendations of the House. These are then acted upon.

New members on the Board should not hesitate to request clarification of points on which they are not clear. It will be found helpful by new members to review the minutes of the previous Board meeting.

The Board of Management functions as a policy making body. As it meets only twice a year, it is necessary for it to leave the carrying out of approved policies to either the personnel of the National Office, or to committees, such as the Education Committee or the Executive Committee.

DELEGATES

The Delegate serves as the liason officer between the members of the local association and the Board of Management of the A.O.T.A. The importance of this position cannot be over-stressed. The Delegate, in voting in the House, represents every member of the local

association and therefore should be informed as to their opinions, problems, and needs. Likewise it is the Delegate's responsibility to keep the members of the local association informed as to national problems, needs, and changes in policy.

Delegates should be chosen for their ability to do this. Changes in delegates before the expiration of their terms should be avoided.

SPECIAL DUTIES OF DELEGATES

1. To present to their associations through the year all information passed on to them and to keep the Speaker informed regarding their reactions.
2. To serve as deelgate reporter for AJOT.
3. To help the A.O.T.A. committees on special projects as requested.
4. To act as a general information bureau for all requests from the National Office.
5. To answer letters when received.
6. To see that the National Office is informed correctly as to changes in office in local associations.
7. To pass on to the new delegate the minutes and other pertinent material.
8. The delegate of the area in which the annual meeting is held is to be responsible for making sure that adequate space is secured for meetings of the House of Delegates.

MEETINGS OF THE HOUSE OF DELEGATES

Meetings of the House are held yearly at the annual meeting—one prior to the first Board meeting and one or more before the second.

Each affiliated association may be represented by a delegate and an alternate. If both attend, only the delegate may vote for the association, and the alternate is present only as an auditor. If an association cannot send a representative, it may submit a written statement of the views of its members, which will be used as a guide to discussion, but which will not constitute a vote.

Active members of the A.O.T.A. may be admitted as visitors to the meetings of the House of Delegates. Closed meetings may be held by a majority vote of the House.

Special meetings of the house of Delegates may be called when necessary.

SHOP HINTS

To color brass green:

30 grains hydrochlorate of ammonia
120 grains sulphate of copper
1 quart of water

To make brass dark brown or bronze:

75 grains chlorate of potash
150 grains nickel salts
1 pint of water

SPECIAL GROUPS

ARMY

Recognition of the professional value of occupational therapists in fulfilling the mission of military medicine has been recently demonstrated by two activities on opposite sides of the world.

The most recent occupational therapist to be integrated into the Women's Medical Specialist Corps was Miss Lottie Blanton. Miss Blanton, on a six months' leave of absence from the Medical Department of the Army to establish an occupational therapy program in one of the hospitals in Copenhagen, Denmark, was requested to deliver a series of lectures in Stockholm, Sweden. It was here that the military attache executed her oath of office on June 4, 1948. She is now assigned to the Station Hospital Stuttgart, Germany, as the first chief occupational therapist in the European Command.

At home, in the historical city of San Antonio where the story of the Alamo and beautiful Spanish missions contrasts with one of the largest Army Medical Centers existing anywhere, another "first" took place during April. Eight occupational therapists earned the distinction of being pioneer graduates representing their profession by successfully completing the Basic Training Course for Female Officers as full-fledged military officers. The Basic Training Course has equipped them for military service.

Whom do I salute? What does G-2 signify? How does the writing of a military letter differ from that of a regular business letter? These questions and many more are answered for each occupational therapist during her basic military training course which is essential for every officer who goes on duty in the Army.

The eight-week training course offers not only general administration of the Army but interesting discussions of subjects such as "Medical Aspects of Atomic Warfare," "Dynamic Factors in Military Neuropsychiatry," and "Military Surgery and Medicine."

Yes, she does learn the "new look" as to military uniforms and how they should be worn. (The Army gives her $250 with which to purchase her uniform wardrobe). How to return a snappy salute, the symbol of American

soldiers the world over, is also part of her new knowledge.

The first group of occupational therapists who graduated from Basic Training at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas, are, left to right:

Marcia Duehring, Vivian Strickler, Jean Culberton, Ada Marie Bowers, Mabel Eisele, Bernice Hewitt, Jacqueline Wright, Martha Rinebolt.

The Army Occupational Therapy group is gradually expanding. Listed are Occupational Therapists serving at present on a military status in the Army hospitals throughout the world.

	NAME	RANK	ASSIGNMENT	SCHOOL
1.	Aber, Roberta	1st Lt.	Walter Reed GH	B.S.O.T.
2.	Bangs, Barbara	2nd Lt.	Murphy GH	P.S.O.T.
3.	Bettinger, M. Pauline	1st Lt.	Oliver GH	P.S.O.T.
4.	Blanton, Lottie	2nd Lt.	Germany	P.S.O.T.
5.	Bodycomb, Irma J.	2nd Lt.	Fitzsimons GH	P.S.O.T.
6.	Boman, Mary Lou	2nd Lt.	Tripler GH	U.S.C.
7.	Bond, Mildred	2nd Lt.	SGO	Mil-Downer
8.	Bowers, Ada Marie	Captain	Letterman GH	U.S.C.
9.	Coolidge, Marilyn	2nd Lt.	Percy Jones GH	Univ. of Ill.
10.	Crouser, Doris J.	1st Lt.	Percy Jones GH	Mil-Downer
11.	Culbertson, Jean	2nd Lt.	Brooke GH	B.S.O.T.
12.	Deming, Elsie	2nd Lt.	Percy Jones GH	Univ. of N. H.
13.	Duehring, Marcia	2nd Lt.	Walter Reed GH	B.S.O.T.
14.	Duncan, Tommye	2nd Lt.	Brooke GH	U.S.C.
15.	Eisele, Mabel	Captain	Tilton GH	U.S.C.
16.	Erickson, Helen	2nd Lt.	Brooke GH	P.S.O.T.
17.	Fouquet, Dorothy	2nd Lt.	Brooke GH	U.S.C.
18.	Gabler, Helen	2nd Lt.	Brooke GH	Univ. of Ill.
19.	Henningsen, Katherine	2nd Lt.	Fitzsimons GH	Mills
20.	Hewitt, Bernice	2nd Lt.	Walter Reed GH	B.S.O.T.
21.	Hooper, Catherine	1st Lt.	Wm. Beaumont GH	Univ. of Ill.
22.	Knickerbocker, Barbara	2nd Lt.	Tilton GH	Mil-Downer
23.	Kraybill, Margaret	1st Lt.	Mitchel Field, AAF	P.S.O.T.
24.	Lewis, Mary	2nd Lt.	Army & Navy	Ohio State
25.	Lindow, Louisa R.	2nd Lt.	Letterman GH	Mil-Downer
26.	Lund, Ellen Margaret	2nd Lt.	Walter Reed GH	B.S.O.T.
27.	McDaniel, Myra	Captain	Madigan GH	Mil-Downer
28.	McKinnon, Marion	2nd Lt.	McCornack GH	Wayne Univ.

29. Maas, Violet	2nd Lt.	Letterman GH	U.S.C.
30. Maurice, Kathryn	1st Lt.	Camp Kilmer	R.P.I.
31. Miller, Leila	1st Lt.	McCornack	Mills
32. Milne, Alyce	1st Lt.	Tripler	U.S.C.
33. Nachod, Elizabeth	1st Lt.	Brooke GH	P.S.O.T.
34. Nichols, Elizabeth	2nd Lt.	Tilton GH	B.S.O.T.
35. Pierce, Mabel	1st Lt.	Walter Reed GH	Columbia
36. Reilly, Mary	1st Lt.	Inst. of Path.	B.S.O.T.
37. Rinebolt, Martha	2nd Lt.	Tripler GH	R.P.I.
38. Robinson, Ruth	Captain	SGO	B.S.O.T.
39. Schrack, Bertha	2nd Lt.	Fitzsimons	U.S.C.
40. Sheehan, Helen	Captain	McCornack	U.S.C.
41. Strickler, Vivian	2nd Lt.	Wm. Beaumont GH	Mil-Downer
42. Vance, Eleanor	2nd Lt.	Brooke GH	Mil-Downer
43. Viets, Barbara	2nd Lt.	Fort Jay SH	B.S.O.T.
44. Winkleblech, Marion	1st Lt.	Murphy GH	P.S.O.T.
45. Wright, Jacqueline	2nd Lt.	Tripler GH	P.S.O.T.

The Occupational Therapists of Missouri entertained the members of the A.O.T.A. Board of Management and the Educational Committee in St. Louis in March when meetings were held at the Chase Hotel.
A double-decker, open air New York bus was rented to take the guests through Forest Park to a tea at Miss Clotilda Brown's. Can you find a familiar face?

HONORED BY "WHO'S WHO"

The name of Henrietta G. Price (Mrs. Marshall L.), O.T.R., has been entered in the 1948 "Who's Who in the East." Mrs. Price is one of the pioneers in O.T., having been closely associated for many years with both Dr. Wm. Rush Dunton and Mrs. Eleanor Clarke Slagle. She assisted Mrs. Slagle in establishing and directing O.T. at The Phipps Clinic of Johns Hopkins Hospital, 1913-1919. Later she established O.T. at St. Elizabeth's Hospital in Washington, D. C. Since 1920, Mrs. Price has been Director of O.T. and Clinical Training at The Sheppard and Enoch Pratt Hospital, Towson, Md., where she has been a constant source of inspiration to all with whom she has come in contact. Mrs. Price is an active member of the M.O.T.S. and for six years served as its president. She has made valuable contributions not only to the profession, but also to worthwhile community endeavors. The entering of Mrs. Price's name should be considered a distinct honor to our profession.

ANSWERS TO O-TEASERS

(See Page 174)

1. "Localization of function" relative to active exercise in Occupational Therapy means the direction of exercise into the specific area with which we are going to work, with as little compensatory motion as possible.
2. Enuresis
   Cerebral Spastic Infantile Paralysis
   Epileptiform Seizures
   Mental Deficiency
   Meningitis
   Encephalitis
   Acrodynia
   Ataxia
   Lenticular Degeneration
   Athetosis
3. Establish healthy rapport. Create normal atmosphere. Normalize attention span.
4. Preparation of the patient. Preparation of the activity. Tryout performance. Follow-up.
5. 1931.
6. 1938.
7. Rheumatoid arthritis.
8. Joint movement.

Miss Geraldine R. Lermit, O.T.R., Honored

Professor Emeritus Geraldine Lermit (right) receiving Life Membership in the Occupational Therapists of Missouri from Mrs. Edward Keller, O.T.R., retiring president. Presentation was made at the group's annual meeting when Professor Lermit was guest of honor.

Professor Lermit, after receiving her A.B. from Wellesley College and her Ph.M. from the University of Chicago, obtained her professional education from the A.R.C. Teaching Center in Chicago. She served in government hospitals until she was called in 1922 to direct the St. Louis School of Occupational Therapy, where she also contributed widely to the development of the profession and the national organization. She continued as director until 1946 when, largely as a result of her efforts, the school became a part of Washington University Medical School.

RESOLUTION
of the
Occupational Therapists of Missouri

TO WHOM IT MAY CONCERN:

Whereas, she has been a pioneer in the profession of Occupational Therapy, and

Whereas, from 1922 to 1946 Geraldine Lermit was Director of the St. Louis School, serving untiringly in that capacity, and

Whereas, through her enthusiasm and foresight the program of the school grew in scope and breadth, and

Whereas, after the students had gone out into the field she continued to give them encouragement and guidance

Whereas, she has contributed to the interpretation and development of the profession in the community and on a national basis

Therefore, be it resolved that on this thirteenth day of May, 1948, Geraldine Lermit is unanimously elected to Life Membership in the Occupational Therapists of Missouri, by virtue of which membership she is entitled to all privileges and responsibilities of Active Membership, with the exception that she is exempt from payment of dues.

Signed:
MRS. EDWARD KELLER, *President*
MISS MARJORIE BALL, *Vice-President*
MISS GENE E. KUNDERMANN, *Secretary*
MISS FAITH KOCH, *Treasurer*

SHOP HINTS

A finger painting mixture:

1. Mix half of the contents of a box of laundry starch with water (consistency of paste).
2. Add a quart of boiling water and cook until the mixture has a glossy appearance.
3. While mixture is cooling add half a cup of talcum powder.
4. When tepid, stir in a cup and a half of soap flakes.
5. Add oil of wintergreen as a preservative.
6. Pour into jars, adding thinned tempera or poster paint to obtain the desired colors.

To make chrysanthemums and peonies last longer split their stems three or four inches from the end before putting into water.

Water absorption of newly cut poppies and zinnias will be increased if the stem hairs are singed for three or four inches.

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